REHABILITATION RECORD

January and February 1972

Work: Some Ramifications

See pages 3–19

White House Conference on Aging

The second White House Conference on Aging in the nation's history convened in Washington, D.C. from November 28 to December 2, 1971, with 3,400 delegates in attendance. Major purpose of the conference was to learn about needs of our 20 million aging from the older citizens themselves and to develop a more realistic and comprehensive national policy for older Americans.

Planned as a continuous process of growth and not a single event, the conference was preceded by a series of forums, hearings, meetings and other White House conferences at community and State levels in which more than 1 million concerned Americans participated.

The Rehabilitation Services Administration had the responsibility of conducting the session on rehabilitation. Prior to the session, a planning committee prepared a series of recommendations that would be relevant to the needs of the Aging handicapped. These recommendations were presented to and voted upon at a special conference in September 1971, sponsored by the Rehabilitation Services Administration and conducted by the Federation Employment and Guidance Service of New York City. Commissioner Edward Newman, Ph. D., RSA; Mr. John Twiname, Administrator of SRS; and Mr. Robert Ball, Commissioner, SSA, addressed the September meeting.

On December 1, Commissioner Edward Newman made the keynote speech at the Special Session on Physical and Vocational Rehabilitation. Following his address, a panel consisting of E. B. Whitten, National Rehabilitation Association; W. Scott Allan, Liberty Mutual Insurance Companies; Lawrence Smedley, AFL–CIO; Charles Roberts, International Association of Rehabilitation Facilities; and Dr. Leonard D. Policoff, President-Elect, American Congress of Rehabilitation Medicine, discussed the implementation of recommendations presented to the Conference.

The delegates voted unanimously to adopt the recommendations of the September conference and these will be the official recommendations on rehabilitation of the 1971 White House Conference on Aging.

MARY ELIZABETH SWITZER
A TRIBUTE

Howard A. Rusk

How does one pay tribute to a life of total dedication? A life of service built from a foundation of early hardship and sometimes even material deprivation in a warm, close family solidarity of sharing, mutual help, and understanding.

Here the first sinews of character were born like seeds in the damp cold soil fighting their way to the sunshine and blossoming. Mary's consuming desire for education was as compelling as the sun to the flower. Her graduation from Radcliffe was the culmination. Her roots were deep—the stem was strong. Her leaves were bright and shiny. She was ready for challenge, adventure, excitement, and a world to conquer. Washington was that first world.

Her stay at the bottom of the Washington ladder was unbelievably short for a young, naive New England fledgling. She was fortunate to have the abiding friendship of her closest childhood friend, Isabella Diamond, in those early formative and struggling days. For Isabella, a scant few years her senior, was already in Washington. The childhood friendship grew and through the years was cemented into a beautiful relationship of sharing, mutual understanding, and a spiritual kinship that even death did not destroy.

Her love for her family, and theirs for her, was a beautiful and cherished relationship. Her pride in the accomplishments of her sister and brother, and her nieces and nephews and their children were evidenced in the special sparkle in her eyes whenever she spoke of them.

From her first assignment in the Treasury Department, Mary soon was rocketing into new and compelling Washington orbits that were developing in the economic travail that came with the depression of the thirties and the pyramiding problems that were accumulating like storm clouds in war torn Europe. Her knowledge, warm understanding, fundamental honesty, and dedication made her a most sought after "girl-Friday" to the government officials and politicians struggling with these gargantuan problems that often seemed insoluble. These were days when courage was needed in depth and in seeking the solution of these problems and helping those in authority to do so, Mary was a solid rock of dependence, a supporting crutch for the weary and a tiger in battles for the things she believed in.

During the war days Mary became more and more involved in health and medical affairs. She became deeply interested in the debates on a national health service. Her posture was get the facts, weigh the issues, and keep to the high ground of impartiality. As a result she was both respected and trusted by the proponents of a national health service and the opponents in organized medicine—a most unique position. She also served in the war years on the top policy committees on recruitment and assignment of physicians and other health personnel and their utilization in the armed forces. These were years of experience that provided the background of understanding that seasoned her for her great challenge when in 1950 she was appointed Commissioner of Vocational Rehabilitation. She held this position for 17 years.

Here all her life's trials—her victories and defeats—gave her an intricate and sensitive perception of the Washington political high ground and also the dangerous pitfalls. She learned, as few have ever learned, to cut red tape with ruthlessness that was not only refreshing but heart warming.

Rehabilitation under her leadership grew by leaps and bounds both in concept and numbers of the disabled taken back into lives of self-support, self respect, and dignity. The programs of research, training, and service multiplied two fold, then ten fold and on up and up in geometric ratio—the leaders in the Congress listened and became enthusiastic supporters of "Mary's Program."

How did this all happen? Mary became the voice of the disabled—never before had this greatest of all minority groups had a champion who knew their problems and spoke their language. She was not a disabled person but she had a sixth sense of understanding; somehow she knew how it felt to crawl

when it was possible to walk. She understood the sensitive and expressive language of the deaf. She could somehow communicate with the blind in their darkness, and they understood her anguish and her determination to help them.

This was the secret of Mary's unparalled success in rehabilitation. She possessed the empathy, the courage, and the ability to do something about meeting the needs of the halt, the lame, the deaf, the blind, the retarded, the emotionally disturbed, and the socially deprived. Recognizing her great and unique ability in administration, Mary was appointed administrator of Social and Rehabilitation Service when this new agency was created in 1967. She described her reaction to the new appointment:

"I went to bed one night with what I thought was a tremendous budget of more than 300 million dollars and when I awoke the next morning, I found it was six billion dollars."

Here she broadened her concept not only to include the disabled adult, but the handicapped children's needs and necessities, the problems of the aged, welfare with its tremendous problems that were not only monetary but conceptual. All of this she took in her stride and step at a time began to bring order into a chaotic conglomerate. Then as though these challenges in her own country were not enough, she broadened her horizons to the world.

Her first baptism in the international program was at the meeting of the International Society of the Rehabilitation of the Disabled in Sweden in 1951. A small struggling organization organized prior to the war by one of Mary's closest and most respected friends, Bell Greve. Here in Stockholm she saw for the first time a new social phenomenon. People had traveled half way around the globe to try to learn more to help them to help the disabled of their countries. Many were hungry at the meeting but everyone shared. Here is Mary's description of it: "Here I saw a social phenomenon, a milieu in which the have nots loved the haves and no one asked for anything that they didn't say in the next breath, 'and what can I share with you?' "

This was the trigger that launched Mary into a new orbit of action and probably the most important one in her career. A feeling that this was a world problem and something had to be done about it. The lack of interest in the disabled, estimated to be at 300 million, who with just the most simple rehabilitation assistance could go back to life and work, was a festering sore that blocked out any hope of world understanding. It was incredible and cruel to her that a world could spend 200 billion dollars a year for armaments and only a penny per year per person for the 300 million disabled. She realized that these barriers must be broken and the problems of the disabled solved at least to some degree of equity. Here was the greatest opportunity to promote world understanding that would transcend race, creed, color, religion or political boundaries. As one of the leaders in this crusade, she was a zealot with total dedication for the rest of her life.

The ingredients of this beautiful and dedicated life were WORK, UNDERSTANDING, COURAGE, AND LOVE. They have been immortalized by poets who seemed to be writing just for Mary.

WORK—Henry Van Dyke

Let me but do my work from day to day
In field or forest, at the desk or loom,
In roaring market-place or tranquil room;
Let me but find it in my heart to say,
When vagrant wishes beckon me astray,
"This is my work my blessing, not my doom;
Of all who live, I am the one by whom
This work can best be done in the right way."
Then shall I see it not too great nor small
To suit my spirit and to prove my powers;
Then shall I cheerful greet the laboring hours
And cheerful turn when the long shadows fall
At eventide, to play and love and rest
Because I know for me my work is best.

DEDICATION—Bayard Taylor

The healing of the world is in its nameless saints.
Each separate star seems nothing but a myriad
scattered stars break up the night, and make it
beautiful.

COURAGE—W. A. White

I am not afraid of tomorrow, for I have known
yesterday and loved today.

LOVE—Arthur Stringer

I have sought beauty thru the dust of strife,
I have sought meaning for the ancient ache,
and music in the grinding wheels of life.

Long have I sought and little found or got
beyond this truth.
That love alone can make earth beautiful
and life without regret.

We have lost a cherished friend. The disabled of the world have lost their great champion.

Is Salary Important?

DAVID MACAROV, PH. D.

BELIEF IN SALARY as a prime motivator for work is deeply embedded in American social welfare policy, including policies regarding rehabilitation. Despite some overt disclaimers that other factors are equally or more important, much policy and activity continues to be guided by an implicit faith in the "economic man," who is motivated and directed purely by pecuniary considerations. Thus, benefits are pegged below the wage level, and the effect of various types of programs on the incentive to work is studied in depth.

Yet, there is abundant evidence and experience to indicate that—at least at certain levels—salary is really not a very important work motivator. It is true that at or near the subsistence level income as such may be a prime factor in making choices concerning work or leisure, or the kind of work done,[1] since physiological needs—which have been held to be initially most potent [2]—dictate that the amount of income, rather than its source or conditions, be the major consideration. As one moves up the financial scale, however, the importance of salary of itself seems to recede.[3]

This does not mean that income—or its amount—is no longer important at all, for the insatiability of human desires, aided and abetted by the power of advertising; the influence of reference groups; and the desire to engage in relatively conspicious consumption, all operate to keep income within the picture. Income as a work motivator, however, becomes less important when material needs are more-or-less satisfied, and salary begins to be seen more in symbolic terms—as evidence of recognition, achievement, or advancement, on the positive side; and as evidence of unfairness in company policy, or lack of proper appreciation, when negative.

To the extent that salary is not an important work motivator, it may be overemphasized in rehabilitation thinking, counseling, and programs, while true motivators may tend to be overlooked or neglected. This is especially pertinent in dealing with clients who have reasonable or, at least, more than subsistence earning capacities. The role of salary as a work motivator is thus important, and the purpose of this article is to review some of the evidence in this regard, while adding the results of a recent study.

The Herzberg Study

In 1959 Herzberg and his associates studied 203 accountants and engineers in Pittsburgh, asking them to think of a time when they were particularly satisfied or dissatisfied at work and to list the reasons.[4] Since that time, the original study has been

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replicated many times, using different populations and under various conditions, including factories in Finland and Hungary.[5] These studies found that the factors which cause satisfactions and dissatisfactions at work are not the obverse of one another, but that satisfactions stem from the nature of the work itself—enjoyment, feeling of achievement, sense of advancement; while dissatisfactions arise from the circumstances surrounding the work, such as conditions, policies, and relationships. The satisfiers were thus termed "motivators," while the dissatisfiers were seen more as "hygiene factors." To use an oversimplified analogy, a worker might enjoy his actual work, but be bothered by the lack of a drinking fountain. It is unlikely that he would change to a job doing work that he didn't enjoy simply because of the presence of a drinking fountain or a dozen of them. His motivation arises from the essence of the work itself; his mental hygiene is affected by the conditions under which the work is done.

The implication of these studies is clear: A person is more likely to be motivated to take a job by the nature of the work being offered, than by the conditions under which the work is to be performed. Perhaps the most significant (and surprising) of these findings, however, is that salary almost never appears, either as a motivator or as a hygiene factor, in the responses received. In only one of the studies reviewed by Herzberg [6] was salary an important factor, and this was in the case of unskilled hospital employees, one of the most underpaid groups of employees in America.[7] When salary was mentioned by the other respondents, it was, as noted earlier, either as an evidence of recognition, achievement, or advancement; or as an indication of unfair company policy.

These findings have not been without their critics,[8] who hold, among other things, that the critical incident method used biases responses away from ongoing satisfactions or dissatisfactions (such as salary) and emphasizes transient events; that the categories used are not exclusive; and that respondents tend to project failures onto others while accepting personal credit for successes. In view of such criticism, it is not clear whether salary actually plays as little a part in work satisfactions or dissatisfactions as the studies seem to indicate, or whether it plays a hidden, but nevertheless important, role.

A Kibbutz Study

One method of testing this question is to study work satisfactions in a situation where salary cannot be an influence and, thus, to determine whether the same results are obtained. One of the few places where work is voluntarily performed without differential salaries is in an Israeli kibbutz, and the rest of this article concerns the results of a study of work satisfactions in one kibbutz.

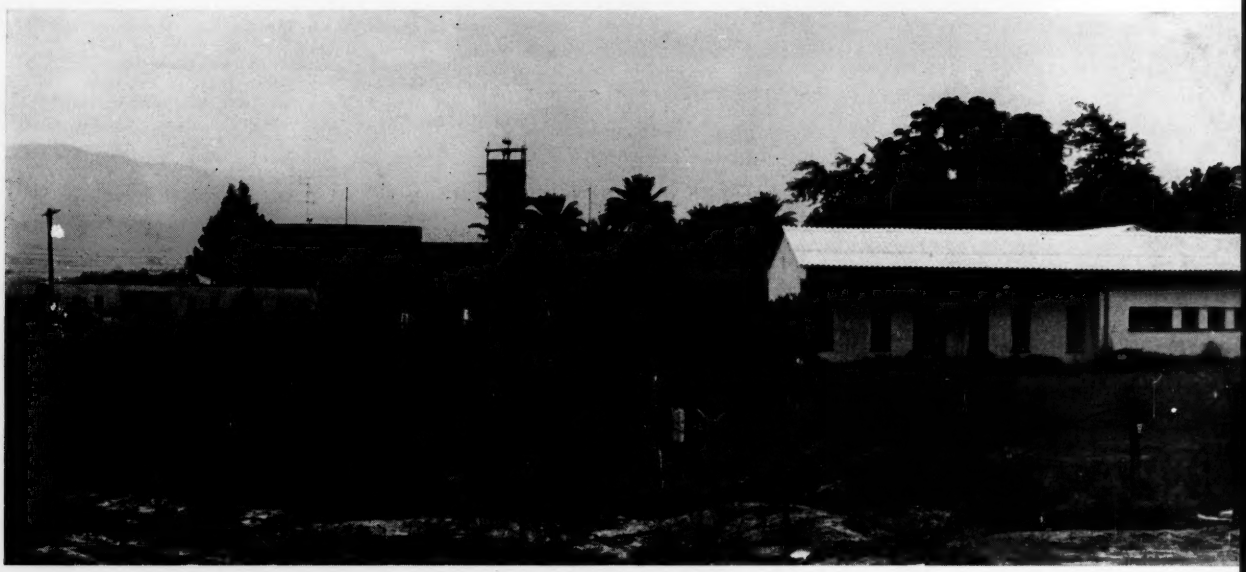
The Israeli kibbutz (pl. kibbutzim) is a voluntary collective settlement, primarily based on agriculture, in which members receive all of their needs and to which they contribute all of their work.[9] No individual production records of any kind are kept, and although members may be known by reputation as better or worse workers, no such distinctions are made in the distribution of goods or services to members. The sole criterion for receipt of a commodity or a service is need, as that is defined by the kibbutz as a whole. Consequently, there are no differentials based on amount or style of work, and, therefore, nothing which can be termed salary operates.

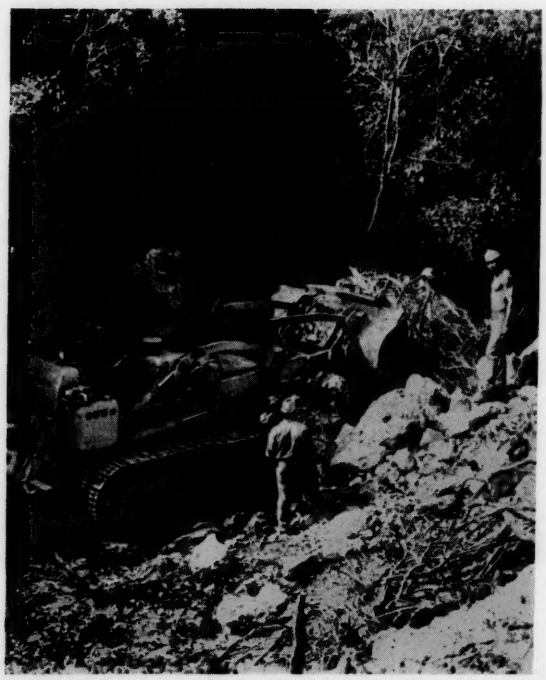
As part of a larger study of work patterns in kibbutzim,[10] 219 members (84 percent) of one kibbutz were interviewed concerning the sources of their satisfactions and dissatisfactions at work. The question was open ended, and respondents were free to say what they wished. When the results were scored according to the same methodology used by Herzberg, which included dropping those factors which did not cause satisfactions or dissatisfactions to at least 10 percent of the respondents, six factors remained.

Of these, one was idiosyncratic to this study, since the kibbutz members interviewed included service workers as well as production workers, and the former gave as one of their major sources of satisfaction contact with the people whom they served—in particular, the children with whom educators and child-care workers dealt.

After dropping this unique factor, the five major sources of satisfactions/dissatisfactions in this kibbutz were:

*Percent Satisfaction**	*Factor*	*Percent Dissatisfaction**
41.9	The Work Itself	14.8
33.0	Feelings of Achievement	17.0





Top photo, barbed wire and fencing give the Israeli kibbutz a foreboding look from the outside looking in. Note observation tower in background. As a "voluntary collective settlement," the inside of the kibbutz buzzes with activity. The two photos above show male and female residents occupied in activities for the common good. In the kibbutz "there are no differentials based on amount or style of work, and, therefore, nothing which can be termed salary operates."

*Percent Satisfaction**	*Factor*	*Percent Dissatisfaction**
28.0	Interpersonal Relations___	20. 5
18.1	Working Conditions_____	28. 4
21.4	Sense of Responsibility____	2. 8

*Totals more than 100 percent since each respondent could give more than one factor.

Four of these five factors support Herzberg's findings. The factors in which satisfactions predominated over dissatisfactions were the work itself, feelings of achievement, and a sense of responsibility—all related to the content of the job. The one factor leading to more dissatisfactions was the working conditions, clearly a "hygiene factor." Only the item of interpersonal relations, which should be a hygiene factor and thus a source of dissatisfactions, shows up as a source of satisfaction, or a motivator. However, the importance of this item as a whole—as compared to the Herzberg series of studies—may be due to the fact that interpersonal relations are one of the most important aspects of the kibbutz as a whole. The entire group may be viewed as a type of extended family and, because of the nature of kibbutz life, relationships cannot be divided between those at work and those at home or after hours. Work partners become social, recreational, neighborhood partners; while family members may become work partners. Interpersonal relationships (with the same group of people) permeate every phase of kibbutz living, and it is to be expected that its weight in work satisfactions or dissatisfactions will be different from other settings.

The remaining five factors resemble the findings of the Herzberg-type studies mentioned above, although the relative weights of satisfactions and dissatisfactions are more nearly equal in the kibbutz than in those studies. That is, the same factor tends to cause both more satisfactions and more dissatisfactions in the kibbutz than it does elsewhere. It is not possible to determine whether this is caused by the difference in methodology, i.e., not using the critical incident method; or the differences in the kibbutz setting; or the absence of a salary factor.

However, the results of this study of work satisfactions in a kibbutz, where there are no salaries, resemble the outcomes of similar studies—in which salary is operative—closely enough to allow one to conclude that, at economic levels high enough above the subsistence line, salary as such is not a powerful work motivator when compared to the intrinsic qualities of the work itself.

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(10) The larger study is supported by a grant from the Fritz Naphtali Foundation, whose help is hereby gratefully acknowledged.

Thoughts On The Work Ethic

The work ethic is not obsolete because:

• As Thomas Carlyle said, there is a perennial nobleness in work, and there is always hope for a man who actually and earnestly works, be he ever so benighted in other ways. "In idleness alone is there perpetual despair."

• Huge is the task of building all of the homes and schools and hospitals, the factories and workshops, airports, roads, and canals, the leisure facilities and equipment, and all other buildings and structures needed to satisfy the requirements of a doubled world population by the year 2000. It is probably a bigger job than all the construction work accomplished by mankind in the past 2000 years. Yet, it must be done in the next 30 years!

• Thorsten Veblen, in his book, *The Instinct of Workmanship,* said that "man is an agent . . . seeking in every act the accomplishment of some concrete, objective . . . end. . . . Being such an agent, he is possessed of a taste for effective work and a distaste for futile effort . . . a sense of the merit of serviceability or efficiency and of the demerit of futility, waste, or incapacity. This aptitude . . . may be called the instinct of workmanship. . . . It is present in all man, and asserts itself even under very adverse circumstances. . . . Much of the functional content of the instinct of workmanship is a proclivity for taking pains. . . . The grave importance that attaches to it arises from its underlying desire to serve the ends of life. . . ."—Bert Griffis

COMMENT: Administrator

Vocational Rehabilitation and the Work Ethic

ADRIAN TOWNE

IS WORK VITAL to social and individual existence or is it just the extension of an obsession born of Christian and Greek myths?

These questions cover all of recorded time. The early Greeks shared with the Hebrews the view of work as a sentence imposed on a sinful world. In the original creation of Greek legend, as in Eden, man had no need to work. Only after his offenses had exhausted the patience of the deities did they require labor as the price for the necessities of life. No longer could man live as did the lilies of the field with every want taken care of by a friendly god.

Try as you will, it remains difficult to divorce the idea of work from its theocentric influences. Many persons today would still support the argument that the necessity for labor is the inevitable consequence of man's fall from grace. And to prove it they can quote the Lord God's admonition to Adam:

Cursed is the ground for thy sake; in sorrow shalt thou eat of it all the days of thy life. By the sweat of thy face shalt thou eat bread, till thou return unto the ground.

Because an eternity of hard labor was promised by the Old Testament God, social legislation has had a hard time providing a rebuttal to his arguments until comparatively recent times. After all, since work is the penalty for man's viciousness, who could make a just complaint against so-called exploitation of the workman? He would not be there to be exploited if it weren't for his unworthiness. By such reasoning man's inhumanity to man could be readily excused, since the penalty had been imposed ages earlier.

With stress on work dedicated to the greater glory of God, long hours and high production led to the development of great fortunes. The 19th century sociologist, Max Weber, expressed this in his *The Protestant Ethic and the Spirit of Capitalism.*

"Religion has psychologically met a very general need," he said. "The fortunate is seldom satisfied with the fact of being fortunate. Beyond this, he needs to know that he has a right to his good fortune. He wants to be convinced that he 'deserved it,' and, above all, that he deserves it in comparison with

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Although hemiplegic because of a stroke, this client (left) learned the art of hooking through Homecraft instruction. One-armed woman (above) is skilled in ceramics. She has her own studio where she sells her work and instructs others in the art.

others. He wishes to be allowed the belief that the less fortunate also merely experiences his due."

The reasoning, of course, was strictly that of John Calvin. He considered work a part of man's debt to God; success in business a sign of God's favor.

"God had determined both whom he would admit to salvation and whom he would condemn to destruction," Calvin said in his *Institutes*.

The work ethic in the Calvinistic sense had for its highest good the making of more and more money. The American bourgeois spirit regarded idleness as sinful and the way of work as the good way. Even the rich who did not have to work felt uneasy when they did not. The great folk myths expressed the value of work. And we cannot forget the influence of Ben Franklin on the subject of work. Poor Richard had countless maxims stressing its importance. "No gains without pains," he said. "No man ever was glorious who was not laborious," he asserted, while stressing that if you "plough deep while sluggards sleep, you shall have corn to sell and keep."

Man throughout the ages has found a deep significance in his labors. Whatever his reversals, however deep his despair, he has gone on working.

Many followed St. Benedict's creed that "to labor is to pray." Others felt that labor gives man dignity insofar as he depends entirely on his diligence and intelligence for his wants, as opposed to pauperism, laziness, and inactivity.

Change came slowly for the worker after the Garden of Eden episode. It took a million years for the Age of Tools to arrive and another 5,000 years for the Age of Power to spread through the civilized world and affect conditions of daily life and labor. But the few years from the 1820's to the 1860's saw the Age of Industry hurdle from infancy to maturity.

Changes were profound. Machines, not men, governed the pace of work; machines, not art or sensitive human hands, governed the motion and shape of work; and machines, not feeling and fellowship, governed the relationship of workers and employers. Working life was stripped of every inherent charm.

Throughout most of history the environment in which man worked had been well defined and relatively stable. The object of man's effort was a finished product or service. There were convenient yardsticks by which man and society could judge the personal contribution. The field was plowed, the shoe

was taken from the cobbler's bench, finished. A man could say, "I did that," secure in the knowledge that no one could deny his claim. But all that fell victim to the Industrial Revolution, and today such tangible measures are also lacking. Tens of millions of people work in industries where the total effort is subdivided into minute specialties, with few seeing the end product.

The Protestant work ethic did not tolerate the change, and its death was due in part to the growth of depersonalized work. In the thinking both of the corporate employers and the trade union members, work came to be expressed mainly in money terms. It was cut off from the sense of creativeness and lost much of its dignity and meaning found in the period of craftsmen in their small shops. The idea of the dignity of work died, according to Max Lerner, not in the "dark Satanic mills," but in the well-lighted, ingeniously laid out, scientifically organized assembly lines and in spacious headquarters and offices of great corporations.

Now some will argue that work is so fragmented and the institutions of work so depersonalized as to require no talents worthy of a man. Many workers thus look elsewhere for fulfillment. Psychological studies suggest that this change may be a contributing factor to juvenile crime and other antisocial behavior.

And what has all this to do with vocational rehabilitation?

Let's return to my opening question:

"Is work vital to the social and individual existence or is it just a religious obsession?"

I believe that today the social and personal values of work are real in spite of the increasing discontents of a complex technological society. Now that the religious obsession with work as duty is dead, some theories of work suggest that modern man turns to useful occupations to escape the boredom they fear more than the pain of labor. This is said to be evident in the variety of amusements and diversions they invent or frantically pursue to occupy themselves when work is finished.

Peter Drucker in his *Concept of the Corporation* notes these observations of the automobile industry:

Work appears as something unnatural, a disagreeable, meaningless and stultifying condition of getting a paycheck, devoid of dignity as well as of importance.

Such concepts of work must necessarily be considered today in vocational rehabilitation planning. But if these theories were broadly representative of attitudes held by the vocationally handicapped, our caseloads would be showing marked decreases instead of the steady yearly upsurge.

Our experience in the Wisconsin Division of Vocational Rehabilitation suggests that among the handicapped there remains widespread desire to resume a useful and productive existence at all levels. Perhaps it is a trainable retardate who strives hard to succeed in the sheltered workshop as his first step toward independence. Perhaps it is a college-caliber paraplegic who wants to make her contribution as a social worker, or a deaf youth anxious for a career in the graphic arts.

These clients have a work ethic which though not Calvinistic, nevertheless shows concern for the dignity of work. If they feel some prodding, it is from society and not God. They want to become contributing members of their community, such as the disability pensioners who apply for VR service, even though their return to work may mean the exchange of their pension check for a smaller paycheck. For them, work is more important than the greater monetary return from the pension.

The day-to-day requirements of a job serve quite literally as occupational therapy and are used as such by psychiatrists with certain patients. As Erich Fromm suggests in *The Sane Society,* man's mode of work is an essential element in forming his character.

Wisconsin DVR takes advantage of the therapeutic aspects of work in the rehabilitation process. One of the more interesting experiments along this line has been a behavior modification effort involving young public offenders. Through operant conditioning techniques using work assignments and rewards, they are hopefully undergoing a change in attitude toward employment and toward society in general. In another situation, psychiatrists at a county hospital have a program which includes stress on the importance of work in an effort to speed recovery of DVR clients there.

A combination of the therapeutic and economic aspects of the work ethic can be found in our homecraft service which is geared to the needs of the homebound disabled. This is our oldest continuous program and the first vocational rehabilitation program in the Nation geared to the needs of the homebound. Here we measure results as much in human as in economic terms.

The homecrafters date from the late 1930's, and though comparatively few of the clients have outstanding earnings from their crafts efforts, the program has added the dimension of usefulness to an otherwise deadly existence. About 600 clients yearly turn out a variety of art and craft products sold throughout the State in Easter Seal Society and Cerebral Palsy Association shops. The sale of these articles last year resulted in over $250,000 being returned to the homebound craftsmen. Many of these people will not compete again in the job market, and, because of the severity of their disabilities, cannot turn out sufficient volume to sustain a profitable business. But the dignity of their work effort in itself provides therapy. Through it, they are making a small contribution to society and thus have a reason for being.

Public offenders today constitute about 15 percent of DVR's caseload, and how does the idea of the work ethic affect them? Obviously, few of them ever felt a religious compulsion to labor toward the greater glory of God. In fact, too many of them lack job know-how and have poor employment histories.

A county judge in Wisconsin recently observed that 80 percent of the criminal cases he sees have virtually no job skills. These men would by necessity have a no-work ethic due to their inability to secure or hold jobs.

DVR and the Wisconsin Division of Corrections have been cooperating in a number of programs designed to overcome the skill deficits and to modify antisocial attitudes. In the course of all this, we hope to develop respect for a work ethic in which the public offender can begin to see positive aspects of employment if not actual dignity in work. But this is not easy, particularly among ghetto youth whose experience with the work ethic has been tragic both from the standpoint of inadequate training and discrimination. This area provides DVR one of its greatest challenges.

Any discussion of the work ethic must necessarily anticipate the industrial utopias in which work will be completely transferred to machines and computers.

But what about the work ethic of the button pusher? That's something to anticipate while pondering Erich Fromm's words:

The danger of the past was that men became slaves. The danger of the future is that men may become robots. Given man's nature, robots cannot live and remain sane.

Work

The following article represents chapter four of a longer work entitled *Rehabilitation: Dynamic of Change.* It is the final report of an SRS-supported research and demonstration grant that underwrote a conference of leading anthropologists who discussed how anthropologists can contribute to rehabilitation.

The conference was held at Cornell University, November 2–4, 1968. Quoting from the final report's preface: "Perhaps the strongest recommendation of the conference . . . was the importance of setting up and financing on a long term basis an advisory study group or committee to serve as liaison between people in rehabilitation and the anthropologists. Such a group would encourage bringing together knowledge already available and immediately applicable to present problems; it would concern itself with finding and interesting anthropologists in the design of cultural innovations (called by one participant, social prostheses), like halfway houses, sheltered workshops, significantly different from those operating in present programs; it would foster research projects and explore the possibilities of training anthropologists to study rehabilitation and to promote effective exchange of knowledge and experience between the practitioner and researcher; it would emphasize the continuing evaluation of their collaborative efforts."

COMMENT: Anthropologist

Or Productive Participation

ELIOT D. CHAPPLE, PH. D.

WORK, IN AMERICAN CULTURE, is too often considered the ultimate value; indeed no matter how broadminded people in the rehabilitation field prove to be, we are likely to find the "vocational" given greater weight than habilitation in our discussions. If a job with some kind of remuneration is not being aimed at as a consequence of our efforts, we have a tendency to feel that our basic goals are being perverted.

To the anthropologist, however, the concept of a job or work differs with particular segments of society; in the United States, its pure distillate is found in those white middle class groups often categorized as those who practice the Protestant or Puritan ethic. In fact, such "values" are far less limited (or more diffuse); black middle class individuals share them as do Jews or Catholics of various ethnic derivations. And so do some who, in the jargon of the classifiers, are lower class.

By contrast, at all levels of society one finds individuals or small groups (and sometimes large ones) for whom work may be necessary as a means of living but who, at the first opportunity, drop all pretensions to gainful employment. And there are others, like the Navajo and other American Indian groups, for whom the idea is almost incomprehensible. This does not mean that they have been unexposed to the "white man's ways" and even, under various forms of pressure, have had to comply. Rather the mutual dependency and sharing characterizing their interactions, and the cultural values which express them, make unthinkable the notion of individual autonomy, of independence. They are indissolubly part of a group and only in rare instances can the mould be broken.

But this kind of symbolic and interactional definition of the roles they are to play is found in alternate forms in many cultural settings, even in the middle classes. For all the folklore on the sanctity of work, achievement of the appropriate patterns of interaction almost automatically negates the utility of so doing—in children and adolescents (if financial need is not present) and among most women. For whatever roles the members of the Women's Liberation Front hope to play, the woman with a family carries out a series of interaction forms, and activities connected with them, which are incompatible with holding a job. Whether it be justifiable or not, most mothers have their hands full with the differential school and activity schedules of their children, preparing the meals, doing the errands, the many forms of shopping and, in intervals of free

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time, taking part, with husband or alone, in various "community" activities, organized around schools, churches, clubs, and associations.

At the other end of the life cycle from the children "fortunate" enough to be spared the desperate search for money from any source are the oldsters, typically those happy retirees of the insurance advertisements, with a new life in Florida on $300 a month plus Social Security. No longer bound to work by the requirements of technological existence, they are, presumably, free until death of the slavery of the Protestant ethic, however much they regard its practice by others younger as the inevitable good of living in our society.

There are many others, those on welfare, those engaged in illegal activities which the participants regard as work, even if the rehabilitator does not, and those who, like the addicts and chronic alcoholics, have given up and float with the moment, only concerned with the means of satisfying the habit which is the world of "work" for them.

Work and Its Limits

If now we ask the anthropologist to aid us in defining work, we have to tell him that besides all these categories of individuals who reject autonomy for themselves, there are many among our clients who are not truly capable of being restored to a fully productive life. Whatever the reason—neurological damage, physical defect, chronic psychotic or addictive states—we may be able to improve and stabilize but only to a limited potential. Hence work, where performance is competitive with the nonhandicapped, is out of the question, at least in the present state of our knowledge.

What we can and do contrive for such unfortunate individuals is a simulation of a job, in a sheltered workshop or its equivalent within or outside an institution subsidized by government or private funds. This in itself may be of fundamental importance in sustaining the individual, particularly where he is imbued with the desire to work, but it can easily become more maintenance therapy than therapeutic if the end is to be complete rehabilitation, that is, autonomy. Such programs are even carried on for clients with terminal illness where the habits of a lifetime of working are too strong to be abandoned.

Since the anthropologist comes to the problem with the background of intimate knowledge of a variety of cultures in other parts of the world as well as in the United States, he is likely to begin by pointing out the cultural relativity of the term, work, or its label, job, in economics. To be useful, he has to go back to the first order abstractions of the micro- and macro-events making up the sequences of activities and interactions.

Two uniformities emerge in so doing, though they may appear to be very primitive generalizations: 1) in every society, there are things that have to be done, some of which can be put off until tomorrow, while others can't; and 2) there are people for whom, and often with whom, these are done who make up the network of interactions in which the individual takes part. In the old days, doing the chores was a normal part of the activity of every household, not merely for the young. It was expected and was done without remuneration. Its equivalents are to be found in every culture.

So for each identifiable culture, which is to say, each group of individuals whose dimensional characteristics are, within identifiable limits, reasonably equivalent, we have to ask what are the "chores," paid or unpaid, regular or irregular, which have to be performed. And, in effect, we have to ask what the anthropological definition of a group turns out to be, at least how we can obtain a working definition by which boundaries can be established.

Boundaries of Groups and Subcultures

A working definition, based on interactional realities, has the following properties:

A group can be treated as a unit system or subsystem (and thus be amenable to analysis) by using the following criteria: 1) interaction measurements of the frequencies and durations of contacts between individuals making up the postulated group are high relative to their external contacts; 2) only a small proportion of the individuals within the group or subsystem interact in external contacts to any significant degree and these relationships are largely dyadic; 3) where large numbers of group members interact with those in another group, these are primarily set or group events which polarize and order relationships, as in conflict situations or rituals; 4) of those contacts which do occur dyadically between individuals in different subsystems, only a few are followed by the occurrence of internal interactional sequences. In other words, transitiveness in such contacts does not commonly occur; thus the thresholds at the contact points are high; 5) these interactional criteria are commonly reinforced by spatial separa-

tion, thereby reducing the potential influence of sensory inputs.[1]

The utility of this definition lies in the fact that it provides us with the most accurate referents of the symbols which people use, apart from those idiosyncratic variants which are the ultimate test of meaning for the individual client. Although people may refer to we, the Americans, or to the Sioux, or to the Omaha, one of the five tribes making up the Southern Sioux, we are in no way certain that any group or series of subgroups make up a homogeneous unit except in terms of the realities of the interactional system. However much we may reify Sioux or Arabs or Americans (United States variety) in terms of high order symbols, the system properties, that is to say the identifiable interdependence of individuals, will only occur in groups defined by the above criteria. Otherwise, we are assuming that symbolic identities are the equivalent of interactional dependence and, as all history demonstrates (Arab "unity" being a good present day example), this is a weak and unstable basis for concerted action.

So what we have to ascertain are those sequences of actions and interactions which make up the "work" patterns of the group. In so doing, we necessarily have to find out how they are interwoven, why the Navajo who qualified as handicapped were performing adequately in terms of Navajo cultural values by doing the chores necessary to a pastoral economy of family group and tribe.

Productive Participation as the Rehabilitator's Goal

If rehabilitation is to mean competent performance by the standards of the group, not of the rehabilitators, then work needs to be redefined, from an anthropological point of view, as productive participation to the degree the individual is capable. Such productivity does imply reciprocity, yet in no way does it need to be symbolized by money exchange. Such values are a consequence of all types of productive participation.

Consider the singer of ballads, the preacher, the healer or even the blacksmith in less affluent societies. What was done was given, a gift in the anthropological sense as Marcel Mauss defined it,[2] but the doing, the gift, entails reciprocity, a gift in return, a gift which in no sense has to mean a computed cash value derived from the rate of exchange. All during our lives—our own lives today in the United States—such exchanges take place informally, with expectations of reciprocity but without the dollar sign tacked on. So work, or the job, for most people, has underlying it the idea of a balancing off; the symbolic statement of the paycheck is only superficially related to what we consider in terms of the emotional-interreactional realities, to be the true (personal and cultural) value of what we have done. Perhaps in the long run, the process of exchange of "chores" may average out; we would be hard put to it, except in the heat of negotiation, to justify the real "economic" values of the give and take.

In considering work, therefore, as the anthropologist looks at it, we have to begin, not with our cultural values, however much they may be shaped by the Protestant ethic and the traditions of vocational rehabilitation. We have to ask what the patterns of work are for the people of the culture from whom our clients come. And this means that we have to determine the mutual dependences of the actions and interactions of the individuals in the group and adapt our notion of "work" to that which has meaning, that which has emotional significance through long habit, for the client.

It is easy to argue that the onus of adaptation is on their hands, that they must comply with our requirements, often sanctified by law or administrative regulations. But we also know, through long experience, that this won't work. We can point to "lack of motivation" as sufficient explanation; with experience, we know that this doesn't really get us off the hook. We are responsible for doing the best we can for the client. If we are to have a sense of professional competence, it is up to us to figure out how to manage a change in this apparently recalcitrant motivational state.

Cultural Elements of Productive Participation

In looking at jobs, therefore, and the beginning adjustments of our clients to them, we need to get down to the operating, the doing level. We have to observe what they can do and what they can learn in contexts appropriate and familiar to them; secondarily, we can then consider how the adjustments they make and are capable of making can be fitted into the limitations imposed by our own cultural restrictions. Hence job or work patterns in our culture have to be broken down into their cultural elements, disarticulated into definable components. Parallelisms must then be worked out between the contexts of situations of the two cultures and their

idiosyncratic variants. Given this, new combinations which bridge apparently insuperable cultural gaps can ordinarily be developed and the rehabilitation process furthered, rather than being stopped by "culture" in its tracks.

This kind of approach does not mean that cultural patterns special to a group and exemplified in the client are automatically preferable. What is appropriate for them, if taken at face value, may have no place in the repertoire of placement choices, or innovative developments thereon, available to the rehabilitation agency. For we are, after all, concerned with habilitation, with achieving for the client his maximum potential in this society since we cannot turn the clock back to the time when other cultures were viable systems. And what still persists may limit the client's opportunity to make a better and more satisfactory adjustment once he experiences it.

An in utilizing anthropologists, we need to be very conscious of their own predilections, their own cultural values. These find their expression in preferences for the different, for the culturally idiosyncratic as against equivalent forms in their own society. This is manageable provided they are held firmly to the level of observable events and recognize that old symbols, derived from native culture and the historical past, may not have the emotional-interactional meanings for the client today which once were associated with them. Further, one sometimes finds a tendency among some anthropologists to downgrade present-day cultural adaptations as inadequate or disintegrate to the degree that they are at variance with the old. But these can be counterpoised to alternate prejudices for middle class culture in the rehabilitators. For both, careful observation of what happens will rescue collaboration and settle arguments pro and con.

If then we accept the anthropologist's point that our cultural definition of work is too limited and that a more general term, usable in every cultural group, can be called something like productive participation, all the anomalies of our own society fall in place: children doing the chores (if they still do), the mother managing home and community involvements, the retirees, still dependent on one another, even the criminals in their illegal activities and, at the very bottom, the sporadic participation of addicts and Skid Row outcasts intermittently active in the search for oblivion.

As we all know, in rehabilitation, we have tended to accept this point of view implicitly, not always seeing how it can be generalized. Programs for homemakers or homeworkers (mother's helper) have long been considered an important and satisfactory type of vocational rehabilitation, appropriate for individuals with particular disabilities. We do not always see that only when economic sustenance cannot be achieved within the group due to restricted resources, as in the case of the Navajo, does a cultural barrier need to be breached. Those who wish to or must move into a different culture have to learn the job roles of our society and sustain themselves by receiving cash for what they do. But if the group can absorb them, the transition need not be forced in terms of middle class values.

Diagnosis of Productive Potential

Whether or not the client has worked before or now faces the necessity of so doing for the first time, what we first ask is, what have you done? If we are fortunate, we try, by various techniques more sophisticated than by using "work samples," to have a chance to observe his actual performance. Many an individual, a housewife, for example, has developed a personal role, a series of interactional styles or forms, supplemented or built around particular technical activities. Granted the limitations of the environmental contexts of situation available within the cultural setting, yet the directions taken provide us with clues to the individuality with which we have to deal.

And it doesn't follow, though the literature of "real-life" rehabilitation is full of instances, that skills exhibited can easily be turned into cash. In fact, the question, more properly put, is whether the time patterns allocated to activities and interactions suggest comparable if not equivalent patterns in the community setting? If technical and interactional skills are present and can be built upon, so much the better. But essential to success is participation in a network of relationships which facilitate and stabilize the rehabilitation process.

At the same time, the scope of productive participation as it can be translated into work in conventional terms may have to be looked at within a system of group rewards. Although the group adjustments of American Indians can be a type case, much effort and ingenuity has been expended in industrial management on group incentives, often running

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COMMENT: Research Utilization Specialist

Utilization of Community Resources

ANNE T. KOHLER

THE OBJECT of community involvement is to assist the process by which handicapped, dependent persons can become transformed into self-reliant, positive contributors to community life. The utilization of community resources for more rapid rehabilitation services to the handicapped depends upon a better understanding of the concept of rehabilitation within the community.

A story told by Philip Schafer to the participants at the Eighth Annual Community Resources Institute [1] illustrates how services can be expedited by community involvement. He told of a man who took his and other families to the woods for a picnic. One of his children got lost. The man asked his friends to help him find his child. They all searched diligently and when they came in and had dinner he asked them to make one more try. They did, but again they did not find the child. The next morning the father asked his friends: "Just so we will not leave any area uncovered, why don't we walk hand in hand and see every inch of the country?" They found the child. He was dead. And they said, "Wasn't it too bad we didn't join hands earlier?" Our challenge now is to find creative ways of joining community hands or suffer the consequences.

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Community Organization

It has been noted that professionals work well together in identifying community problems and planning solutions, but that they find it very hard to alter community structure or to effectively involve lay leadership for the legislative support necessary to bring about change. Serious gaps in services to the disabled have resulted from insufficient, inaccurate, and incoherent interchange of ideas and information. In spite of these hazards, governmental and voluntary agencies have increasingly become partners with one another hoping, no doubt, for an improved ability to communicate frankly and effectively.[2]

Past agency attempts to combine information in central registry produced tremendous retrieval problems. The system proved burdensome, time consuming, and so difficult to utilize that each agency elected to keep its own records. But the arrival of the computer with its information retrieval capabilities makes a central registry practical. A centralized computer with terminal ends connecting the participating agencies could simplify and expedite services to countless disabled. For a number of years, the Maryland departments of vocational rehabilitation, labor,

social services, health and education, for example, have successfully shared a general health evaluation record.

In recent years, efforts have been made to educate and involve community leadership for planning community rehabilitation needs. The entire community, according to Daniel Sinick,[3] is in need of education regarding the employment problems of disabled persons. Enlightenment is needed because the problems of employment frequently reside in the community rather than in the disabled person. Even though "fair employment" and "equal opportunity" are familiar concepts to the community, many disabled persons are barred from employment by prejudice and unintended discrimination. The community must assume much of the responsibility for employment practices found in preemployment medical examinations, arbitrary education requirements, and architectural barriers.

Orientation of community leaders was explored by the University of Arizona [4] by bringing together the community leadership, assisting them in achieving an understanding of community needs and services (pertinent to rehabilitation), and stimulating community action needed to sustain the vocational rehabilitation client returning to the community. The institute promoted (1) planning for balanced community services, (2) awareness of duplicated services costs, and (3) recognition of the need for a priority setting of services. Subsequent institutes underwrote the first California Community Planning Council with an advisory committee to the county welfare department. Arizona planned, designed, and built a rehabilitation center under the guidance of a community planning council.

Planning councils, similar to Arizona's, are needed to foster community education and coordination nationwide. Through these councils, clearinghouses with job opportunities for the disabled job seeker could be established, fundamentals of on-the-job training could be advocated, and an employment exchange could provide an opportunity for skeptical employers. Because employers are usually impressed by a demonstration of work performance, a community coalition would involve more and more employers. Wherever employers are invited to work with placement people, more and better placements for the handicapped result.

The Opportunities Industrialization Center (OIC) in Denver is a multiagency program located in the model cities area. OIC offers self-help services to the disadvantaged [5] through arrangements with the division of Rehabilitation Service Center and the Colorado State Employment Commission. The welfare office is conveniently located within two blocks. The uniqueness of having all of these offices in close proximity offers much towards the "service center" concept State agencies across the nation are trying to achieve. Job opportunities should be greatly enhanced through this collective effort.

Clinic on wheels serves South Bronx's 350,000 residents from 3 stations within 12-block perimeter of Lincoln Hospital. Services include physical examinations, counseling, occupational therapy, hearing and speech testing, and more.

In the South Bronx, there are three community centers. The centers function as mental health outposts for Lincoln Hospital.[6] Any of the area's 350,000 Puerto Ricans, Negroes, and whites with any kind of problem can walk in and get immediate help. The social workers in these centers are persons from the neighborhood who share the poor's experience and background and the burdens of slum life—faulty education, ghetto housing, discrimination, unemployment, disturbed family members, and shattered self-esteem.

Each neighborhood center, with its 8 to 12 workers and 1 to 2 supervisors, touches the lives of at least 26,000 people in a year, and costs about $50,000 annually to operate. The American Psychiatric Association conferred on the imaginative Lincoln program its 1968 Silver Achievement Award. It is now serving as a pilot model for the training of

community workers in other parts of New York City.

As the unemployed become employed the tendency is for the newly employed to vacate the depressed area and head for greener fields where the schooling, housing, and transportation are better. This results in a loss of a tax-paying citizen. The creation of *community health centers* [7] might be an incentive for the newly employed to remain. It could be a source of training and employment as well as a provider of health services. Natural outgrowths would include job staffing for day-care centers and training of foster day-care parents. Home care services for the bedbound could be a focal point for health and housing. Recreational services for the young plus the mobilization of groups of people around specific issues—getting new traffic lights, preventing lead poisoning, attacking health problems such as obesity, alcoholism, etc.—are all potentially natural extensions of a health center's functions.[8]

In 1948 New York City's Fountain House, with business acting as a partner, organized a pilot demonstration center in the field of psychiatric rehabilitation. The objective was to create and provide more effective rehabilitation services to facilitate community adjustment of psychiatric patients.[9] Today more than 160 members go to work in the community daily as part of their rehabilitation. Over a period of a year some 600 members gain actual work experience with competitive employment in commerce and industry. Fountain House "members" meet the standards required for the job, and the employer receives no subsidy for hiring them. Many of the employers are nationally known (Sears, Roebuck and Newsweek Magazine) while others are local (advertising firms, banks, restaurants, cafeterias). In most cases the experience has been mutually beneficial.

Industry Utilization

National surveys indicate that where there is employer resistance to hiring the handicapped, three factors are largely responsible: (1) lack of understanding, (2) lack of accurate information, and (3) prejudice and misinformation.[10]

Most employers have no written policies for the employment of qualified handicapped personnel. Many employers reemploy only their own job-disabled employees. Hiring practices vary. Large companies frequently rely on foremen or other supervisory personnel to select job applicants. It is usually less bothersome for them to employ available, unimpaired applicants.

The impact of automation in the next few years poses a tremendous problem for rehabilitation. Increases in job opportunities lie in skilled and semiskilled occupations.

Immediate action is necessary not only to ensure a properly trained work force, but to carve out a place for the handicapped employee. Future work opportunities will lie in totally different areas than they do today.

"In 1910 it took about 50 percent of our manpower to produce enough food for us. Today, it takes about 7 percent of our manpower to raise more than enough food for us, plus a surplus. We once needed about 50 percent of our manpower for the industrial force and now, we need less to produce all the goods that we need, both hard goods and luxury items. We are moving into a new period where we are going to demand more and more services and more and more people are going to earn money this way." [11]

Contacts between DVR and industry for group on-the-job (OJT) training and group employment (part or full time) is a tool that could be used to help meet the needs of both industry and handicapped workers. As automation begins taking its toll, effective use of OJT group contracts could bridge the gap for the handicapped worker. Institutions should be encouraged to contract with workshops for needed manpower. DVR needs to foresee the possibilities inherent in group contracting and take the leadership in promoting its use.

Organized Labor and Rehabilitation

Organized labor's concern with the needs of disabled persons takes on special significance because it represents the largest single body of consumers who are in a position to do something effectively to improve employment opportunities for people who are stricken by disabling conditions or accidents.[12] Labor union members and their immediate families represent about 50 million people.

One of the earliest cooperative programs initiated between organized labor and a governmental agency was the Kaizer-Frazer UAW–CIO Social Security "Fund" and the Michigan DVR.[13] This program was created to assist with the problems of disability

that affected employment. It demonstrated for others an approach by which State and private funds could be pooled and matched with federal funds to finance a broad range of rehabilitation services. Established in 1948, it was the first health and welfare fund negotiated in the automotive industry to provide hospital, medical, surgical, group life, and temporary disability insurance benefits for its members. In July, 1957 the "Fund" authorized $50,000 for use in rehabilitating and training members who could meet DVR criteria of eligibility. The "Fund's" $50,000 drew approximately $63,000 in federal money, making a total of $113,000 for case services.

There are four basic features to the Kaiser-Frazer program:

- The creation of a pooled fund in which moneys appropriated by the Kaiser-Frazer UAW–CIO Social Security Funds for vocational rehabilitation services are matched by the Federal Office of Vocational Rehabilitation program on the same basis that State appropriations for these services are matched federally.
- The fund conducts an intensive screening of former workers who take a complete diagnostic physical examination, provided as another benefit of the fund. The screening of these examinations serves to identify those persons who might benefit from rehabilitation services. Referral by the fund is made after a personal interview with the individual. Also, the State program accepts referrals of other Kaiser-Frazer employees referred to them by other sources and clears with the fund.
- The actual rehabilitation services are provided by the Michigan DVR which retains responsibility for determining eligibility for the State-Federal vocational rehabilitation program.
- A close working relationship exists between the fund and the various State rehabilitation district offices, including the exchange of essential information and progress reports by the State program on the respective status of each individual served by the joint program.

Today organized labor carries a dual role, the role of spokesman for the working force and the role of representative for citizens concerned with individual community and national well-being. Many opportunities exist for organized labor to participate in and support organized rehabilitation services. Areas of involvement with organized rehabilitation have included and include:

- A major role in the work of the President's Committee, as well as State and local committees promoting the employment of disabled persons.
- In several States, representatives of organized labor are serving on advisory committees organized by State vocational rehabilitation agencies and have given effective support to efforts to expand State programs for disabled persons.
- Supported the establishment of rehabilitation centers in many ways, including the raising of considerable amounts of money, and by directly contributing labor, materials, and equipment.

A comprehensive workbook, *Labor and Rehabilitation Handbook for Local Unions,* was developed and published in 1963 by New Jersey union leaders to assist their members in obtaining rehabilitation services. Since then the handbook has been adopted by the National Institute on Rehabilitation and Health Service and given national distribution. When knowledge of available rehabilitation services became known to local unions, organized labor began to support efforts to make rehabilitation an integral part of their benefit programs. In a few States, significant improvements have been achieved in workmen's compensation by way of promoting the utilization of medical rehabilitation services in these programs.[14]

In Minnesota a labor representative acts as liaison between the Minnesota DVR and organized labor. He is involved in educating first line union officials about DVR services. He assists in the identification of workers who are in need of VR services, coordinates referrals of such workers to the appropriate offices, and promotes the employment of the handicapped. In addition, he encourages training VR personnel to assist labor union personnel in the identification of jobs that could be performed by the handicapped.

Weiner's study [15] involving the world of work and mental health services in the men's clothing industry was cosponsored by the New York Board of Amalgamated Clothing Workers of America and the New York Clothing Manufacturer's Association. In the initial stages of the project, Weiner found labor's attitude a problem. The solution was relatively simple, however. Labor had three major needs: [16] (1) The union was under pressure to maintain an experienced labor force for the industry; (2) the union's tradition and desire for a community image as a socially responsible pacesetter that is hospitable to pioneering programs; and (3) The union's

constant search for new personal services which will help maintain the loyalty of its membership. By attempting to satisfy these needs, the key to gaining union commitment and participation was found. The project was successful. (See, also, "The Blue Collar Worker and Psychiatry: A New Alliance," *Rehabilitation Record,* July-August 1969.)

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Work Or Productive Participation

(Continued from page 14.)

aground on the shoals of individual autonomy. The Navajo would, no doubt, find the label of the "team" surprising, yet every culture has intervals of time when just such productive participation takes place, sometimes in getting food, ordinarily in rites and ceremonies, and, of course, in conflicts with other groups.

What is needed, therefore, in defining work possibilities for any client is a detailed description, as much as possible by direct observation, of the cultural sequences in which he has taken part, even if they would not be so labeled in our cultural terms. This is, of course, particularly appropriate for the culturally disadvantaged and for all those handicapped where intervals of productive performance can be identified. For those who have been long handicapped and where the handicaps, and the environment in which the client has been living, severely limit the potentialities of performance with others (and hence of evaluation by observation), there is no alternative except to devise environmental situations, often in workshop settings, to see what will happen.

Productive participation and performance as a guiding principle can be a useful means of transition to work styles available and accepted in our own society. It has its utility, therefore, as a complex of patterns of behavior with direct equivalences in a job-oriented society, as a basis for accepting substitutive processes which still leave the essential pattern whole and, of course, as a construct where group participation and group rewards are technologically feasible.

Unwillingness to broaden the concept of work to include all forms of what we have here called productive participation is to a large extent a consequence of our own culture of rehabilitation. It is a product of our middle class orientations, our habitual roles as professionals, and the institutional and symbolic frameworks within which we work. All of these need to be looked at with the eye of the anthropologist to make clear how much of what we do has scientific validity and how much is simply the habits and customs of a tribe of rehabilitators.

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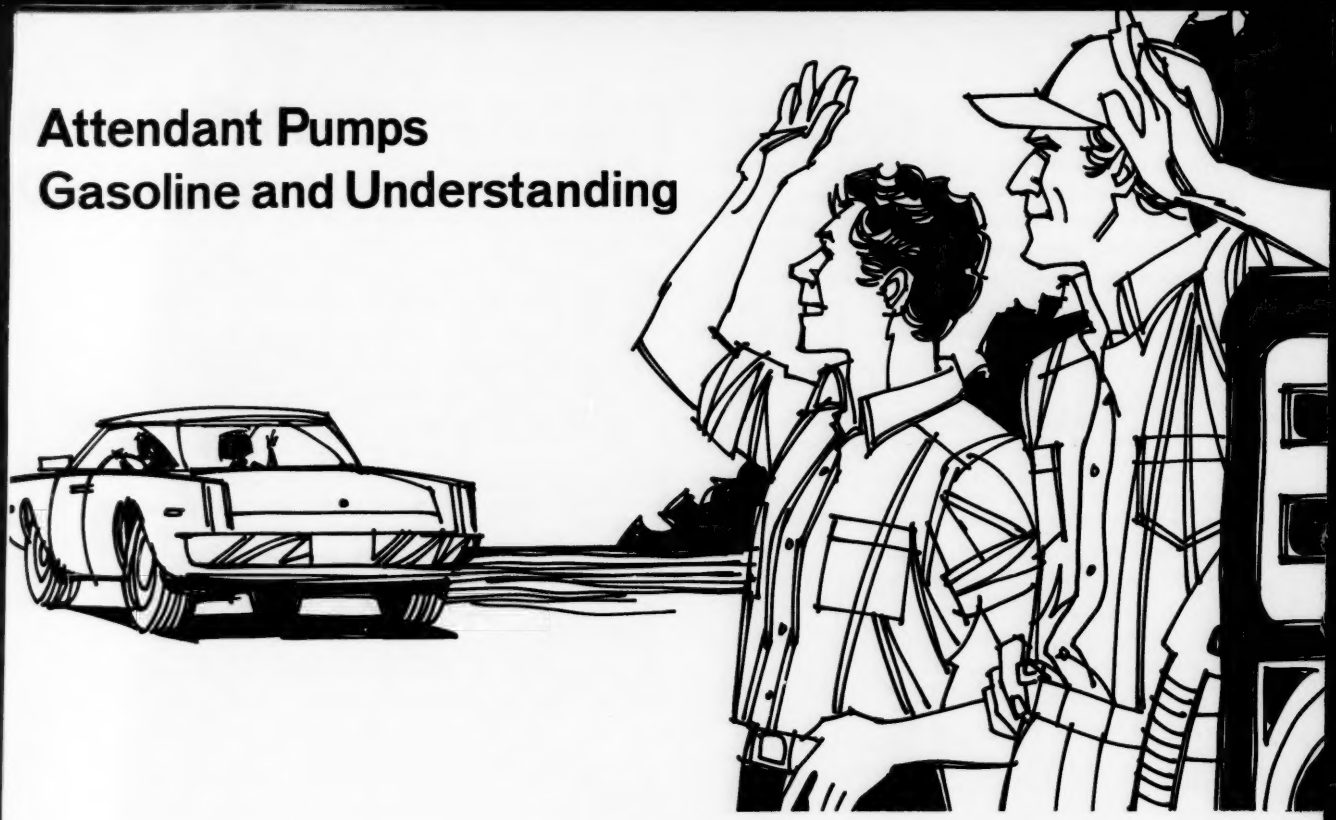
Attendant Pumps Gasoline and Understanding



Bernard Posner

My wife and I drove into the gas station at 8 o'clock that Saturday morning, a rattling and clanging under the hood of our new blue car. We were on a back road, 30 miles South of Philadelphia, heading for Washington.

Two men standing side by side watched us pull up. One was tall, sandy-haired, square shouldered, in his 30's; the other, shorter, black curly hair, laughing eyes, in his 20's.

"Fan belt?" I guessed.

"Water pump," said the tall man.

"Yeah, water pump," echoed the shorter man.

The tall man who owned the station said he'd try to locate a new water pump, but that it would take a couple of hours. Our faces fell.

He invited us into his small office. To make conversation he said, "Been visiting relatives in Philly?"

"No. I made a speech last night at a Retarded Children's Association banquet."

"I think my helper, Chuck, is retarded," he said. I thought this was one of those sick jokes—the word "retarded" as a gratuitous insult. "No, I really mean it," he insisted. "C'mon in the repair shop with me."

He talked as he started removing the damaged water pump. His name was Pete; he had owned the station for a year. Chuck was outside, servicing customers.

"Chuck lives across the street in that old farm house," Pete said. "When he came to work a year ago, he couldn't count beyond ten. And he couldn't sign his name; he used initials, C.J."

"His first job?"

"No, his second. He worked for a while in a slaughter house, slitting the throats of cattle. All day long, killing cows."

"First thing I did," Pete recalled, "I taught Chuck to count to 100. That took weeks.

"And I taught him to write his name. I made him sit in the office over there, and write each letter 5,000 times. He sure learned!"

Pete had the water pump almost completely disassembled. He called outside to Chuck. "Chuck, how about bringing me the 5/8-inch wrench?" Chuck came running, wrench in hand. He went back out to take care of a customer.

Mr. Posner is Deputy Executive Secretary of the President's Committee on Employment of the Handicapped.

"Chuck don't know 5/8 from a hole in the ground," Pete said. "But I showed him that a 5-slant-8 means 5/8; or that a 1-slant-2 means 1/2. He doesn't have to know what they measure as long as he can bring me the right wrench when I need it."

Can Chuck handle money? Well, yes and no.

He has a tough time with change, Pete said. To buy cigarettes from the machine, he puts in a coin (he's not sure what coin) and pulls the handle. If nothing happens he puts in another coin and pulls the handle. And another. Finally, when enough money is in the machine, out pops the pack of cigarettes with the correct change. Who needs to count?

"I let Chuck carry a roll of bills in his pocket, same as all the other gas station people," Pete said. "Look at him." Chuck was standing by a gas tank, proudly fingering his money.

"I also let Chuck go to the bank for me. He carries a lot of dough, couple of thousand dollars at times. First he'll go home and shower and change his clothes. Then he'll get over to the bank and strut in like he owns the place. It's good for him. Makes him feel like he's a somebody."

The new water pump had arrived. Pete was installing it.

"I been taking Chuck to some good restaurants. He had such a crummy life I thought it's time he got some nicer experiences.

"First time we went, I ordered a martini. Chuck decided he'd have one, too. First martini of his life.

"He tasted it and made a face. He called the waiter. 'Bring me a Seven-Up.' He mixed the martini with the Seven-Up. 'Man, that's drinkin,' he said. He's been ordering it ever since."

The gas company held a meeting for station owners in the Philadelphia area. They were invited to bring their most promising employees. Pete brought Chuck.

Later, Pete asked, "How did you like the meeting?"

"Boy, did you see all them fancy lights in the ceiling of that room?"

What happens after work?

"Well, Chuck goes home at 5. He shaves and showers and puts on his good clothes. Then you know what he does? He comes right back over here. Just to hang around. This place is his life. His whole life."

Finally the water pump was installed. We were ready to leave.

I took Chuck aside. "Do you like Pete?"

"Like a father," Chuck said earnestly.

I paid the bill. "You like Chuck?" I asked Pete.

"Like a son," he said.

My wife and I drove out of the station. Pete and Chuck were standing side by side. Pete waved. Chuck waved.

We watched them through the rear vision mirror. A bend in the road and they were out of our sight. . . .

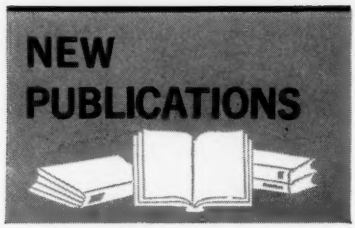
THE GAP BETWEEN MAN AND MACHINE

The following is quoted from a paper, "Human Motors And Their Substitutes," by J. V. Basmajian, M.D., and published in the *Bulletin of the New York Academy of Medicine,* June 1971, page 676:

Some of the loveliest medical engineering solutions end up on the shelf because they have ignored or slighted the human antipathy to harnesses and yokes. We could learn a great deal from dentists, who have the longest experience in this field. The triumph of American dentistry seems to spring from its success in putting hardware into our mouths while we pay through our noses. When rehabilitation engineering approaches 10 percent of the success of modern prosthodontics, it will be a very bright day indeed for the physically handicapped.

Our knowledge of tolerances to machines and gadgets by handicapped persons is faulty. Only basic applied research can help to bridge this gap. Why does a patient fitted with a beautifully tooled upper limb prosthesis remove it as soon as he gets home, and leave it there until his next visit to his physician? Why does this little old crippled lady prefer to maneuver her rocking chair around her living room while a modern lightweight wheelchair stands unused in the hallway? These are questions not only for physicians but for psychologists, sociologists, and other experts in behavior as well as for engineers, metallurgists, prosthetists, and many others.

The tolerance of the whole patient for the equipment is just as important as the tolerance of his skin surface to which it must be applied. There are no easy solutions and the answers will not come by accident. The progress made to the present time is so small that anything accomplished in this field is called a major breakthrough.



Research and Training Center In Vocational Rehabilitation, RT–14. School of Education, University of Pittsburgh, Pittsburgh, Pa. 15213.

Abstracts of Articles On Assessment And The Socially Handicapped. Now in its second volume, this publication exhaustively abstracts several of the magazines and journals in the rehabilitation field. The abstracts are presented in 5x8 tear-out card form for easy storage in alphabetical order by author. A key-word index is also provided for easy identification of subject matter.

Psychiatric Rehabilitation In the 70's, Alcoholism, And Drug Abuse—A Fresh Approach. This is a product of a 3-day Region II in-service training session held in Pittsburgh, Pennsylvania, in April 1970. It carries papers presented by E. B. Whitten, June Christmas, M.D., John Ellis, and Adelaide Johnesse. It also reproduces the highlights of four discussion groups.

The Physically Handicapped and The Community. Louis A. Michaux. Charles C. Thomas, 301–327 East Lawrence Ave., Springfield, Ill. 62703. 122 pages. $6.75.

The internal and external ecology of handicapping conditions is presented by the author whose point of view is that of an insider looking out. Since he is himself a handicapped person (victim of cerebral palsy), much of his source material is subjective, yet the overall presentation has an objective stance.

The book should be a good reference for counselors to recommend to newly disabled persons. It should also prove a valuable insight to the counselor himself.

Mental Retardation: Readings and Resources. Jerome H. Rothstein, editor. Holt, Rinehart and Winston, Inc., 383 Madison Ave., New York, N.Y. 10017. 696 pages.

As a second edition, this book retains only 17 of the 56 articles that appeared in the first edition. The new selections represent the expanded activity that has occurred in the field since the first publication. Most of these new selections were published between 1965 and 1970.

The general areas covered are assessment and diagnosis, learning theory, education, community day care, institutional care, programs for the adult, communicative skills, parent counseling, research, organization and administration of State and local programs, and a look at the future which is a summary of the Report of the President's Panel on Mental Retardation.

A sizable appendix brings together much valuable resource material, including an annotated listing of 150 films on the subject.

Personal Money Management. Braille and talking book editions. The American Bankers Association, 90 Park Ave., New York, N.Y. 10016. Available through local member banks of the American Bankers Association.

This booklet covers such topics as: How to get more out of your dollars; what you should know about saving, spending, housing, insurance, college costs, investing, using credit, and planning your estate; and how much you are really worth. Counselors to the blind may find it a useful money-management reference for their clients.

Training Nonprofessional Community Project Leaders. Monograph Series number 6 of *The Community Mental Health Journal.* Janice R. Neleigh, R.N., Frederick L. Newman, Ph. D., Elizabeth Madore, M.A., and William F. Sears, M.D. Sheldon R. Roen, Ph. D., editor. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025.

This monograph reports the major research findings of a 5-year training project, funded in part by a Public Health Service grant from the National Institute of Public Health.

The report deals with the backgrounds, selection, and training of project leaders, the use of consultants with aides, role responsibilities, role expectations and status, and approaches to project development.

Mental Health Related Activities of Companies and Unions. Elizabeth J. Slotkin, Leo Levy, Edwin Wetmore, and Ferdinand N. Runk. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 91 pages. Paperback. $4.95.

This book is based on a survey of the services that companies and unions provide for their employees and members in coping with various life crises situations in the prevention of mental illness.

The study, made in the metropolitan Chicago area, covers assistance with family and personal problems, assistance with financial problems, work related problems, recreational activities, automation, retirement, mental health education, medical service and insurance, alcoholism, counseling programs, and hiring practices.

The Rehabilitation Workshop and the Foreman's Role. Everett H. Barton, Jr. Rehabilitation Workshop Administration, College of Business Administration, University of San Francisco, San Francisco, Calif. 94117. 88 pages. $2.

Each section in this training guide is followed by a self-study exercise to allow the student foreman to assess the material provided, and the material provided looks at the purpose and nature of the workshop organization, the foreman's role in the workshop, and the knowledge, skill and personal attributes required by the foreman.

The publication is presented in looseleaf format for easy insertion of additions or personal comments.

Selected Rehabilitation Facilities In The United States: An Architect's Analysis. Thomas K. FitzPatrick, F.A.I.A. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 58 pages. 65 cents.

The author is Dean Emeritus, School of Architecture, University of Virginia. His work is based on a research study that took him to most of the continental States and to Puerto Rico. The study sought to identify rehabilitation facilities where new and progressive concepts in programing are in operation. The book documents in photo, text, and floor plan the most advanced ideas in the planning and design of rehabilitation facilities.

The First Phase In Development of A Field Research Model For The Educable Mentally Retarded Special Classroom. B. E. Romo, A. S. Halpern, and H. J. Prehm. Rehabilitation Research and Training Center in Mental Retardation, College of Education, University of Oregon, Eugene, Oreg. 45 pages.

The R&T Center is conducting three projects to assess the progress of educable mentally retarded pupils in special secondary classes. This is a report of one of the three whose purpose is "to develop procedures for longitudinal studies of pupils' success." In constructing its model, the researchers hope to "encompass in manageable form the great variability to be found in the real world of secondary educable mentally retarded classrooms."

Mental Health Services and the General Hospital. American Hospital Association, 840 North Lake Shore Dr., Chicago, Ill. 60611. 49 pages. $1.50.

According to the foreword, each community should provide "mental health services to the right people, in the right combination, at the right time and place." Among other ways this goal is accomplished, the foreword goes on to say, is by developing "a dynamic, innovative delivery system that is continually evaluated and modified." In this context the monograph discusses the general hospital as a resource, service planning, the elements of service in a program, physical facilities, legal aspects, sources of financial support, and the written service plan.

The State of the Art of Volunteering In Rehabilitation Facilities. Goodwill Industries of America, Inc., National Auxiliary to Goodwill Industries, 9200 Wisconsin Ave., Washington, D.C. 20014. 59 pages. $2.

As a report of the first phase of SRS-supported research entitled, "The Use, Recruitment, and Training of Volunteers In Rehabilitation Facilities," this volume surveys (as its title indicates) the state of the art in volunteerism. In phase two, instructional material will be developed, and, in phase three, the instructional material will be evaluated.

The present report is based on four questionnaires sent to executive directors of nonhospital facilities and administrators of hospital facilities, presidents of auxiliary organizations, volunteer coordinators, and individual volunteers. A discussion chapter is devoted to analysis of each group of respondents. Chapter 2 of the report gives highlights of the study which include, among others, comments on volunteer numbers, activities, and characteristics, and attitudes toward volunteer programs by executive directors and administrators.

Blindness 1971. Isabella S. Diamond, editor. American Associaton of Workers for the Blind, Inc., 1511 K St. N.W., Washington, D.C. 20015. 242 pages. $3.

Two deaf-blind poets, Richard Kinney and Robert Smithdas, lead off this 8th annual publication with three poems apiece. The indepth articles appearing in the annual compilation are executed by authors "commissioned to conduct the essential research and prepare the articles so that their continuing value will be assured."

Some of the articles represented include comments on mobility, counseling, the retarded blind, and volunteer transcribers. An article by Martin E. McCavitt, Ed.D., Chief, Division of International Activities, SRS, reviews the research work going on and SRS-sponsored in several foreign countries.

Visual Prosthesis. T. D. Sterling, E. A. Bering, Jr., S. V. Pollack, and H. G. Vaughan, editors. Academic Press Inc., 111 Fifth Ave., New York, N.Y. 10003. 382 pages. $18.50.

On June 2–4, 1969, some 50 investigators in neurophysiology, neurosurgery, engineering, and computer science met at the University of Chicago. This is a report of that meeting which was concerned with the different ways blind persons could be provided with artificial vision. The document is valuable for the information it provides on current research, findings of past research, and what can be expected in the years ahead in the artificial production of vision by the use of special devices to see and record visual impressions on the brain.

Coronary Heart Disease Rehabilitation. Cardiac Rehabilitation Unit, University of Colorado Medical Center, Denver, Colo. 80220. 34 pages.

The inpatient and outpatient care program conducted by the cardiac unit is described in this monograph. A brief discussion concerning program goals and operations is followed by guides for the cardiac's care in the hospital, in occupational therapy, and by the rehabilitation nurse.

OHIO'S PROJECT PREP

Roger L. Brubacher

It was said of Thomas Edward Lawrence, later to become known as Lawrence of Arabia, that he was a "dangerous" man because he wanted his dreams to come true. Often, to be a man it is little more than to have dreams. Some men, however, have a better chance to achieve their dreams than do others.

Take Jim Smith (fictitious name), for instance. Jim, a recent university graduate, has most of the qualities industry purports to look for in a prospective employee. He is young, college educated, has a "good family" background, and shows a history of involvement in activities both socially and organizationally oriented. These attributes, coupled with past scholastic achievement and recruiter reports, indicate Jim Smith has both a good chance and the motivation to succeed.

John Doe is a different story. The only thing he and Jim Smith have in common is youth. John never knew his parents, an early record of constant truancy and incorrigibility landed him in the Fairfield School for Boys in Lancaster, Ohio at the age of 16. A year later he was transferred to the Mansfield Reformatory where he spent 3 years before being released.

At 21 he was back on the streets, and in less than 2 years he became involved in a restaurant robbery, was apprehended, and placed on 3-years probation. During probation he committed grand larceny (breaking and entering), was apprehended again, and returned to the reformatory. Subsequently he was placed on parole, violated this parole, and ended up at the London Correctional Institution. Captured after an escape attempt from London, John celebrated his 25th birthday as an inmate of the Ohio Penitentiary.

Two young men. Two very different social histories. The first apparently programed by birth and fortune for success; the other a major problem faced by the corrections field in Ohio and all over the country. He is perhaps destined to be no more than a statistic lumped in penology books under the heading—*RECIDIVISM*.

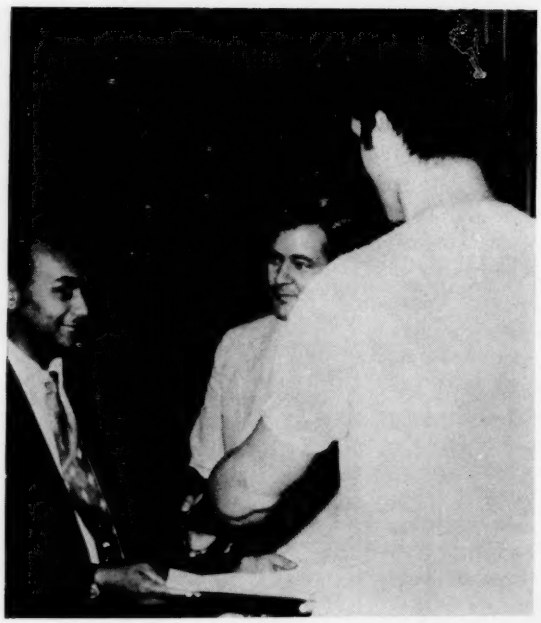
The term refers to former inmates returned to prison a second or third time for additional criminal and/or parole violations, the classic example being the "three-time loser" often referred to in gangster films, circa 1930.

Statistics compiled in the Buckeye State by the Adult Parole Authority (APA) in 1969 show 802 men were returned to prison for additional offenses, or for breaking parole. Fully one-fifth of those returning to an Ohio penal institution during the year were brought back at some point during their parole.

According to George F. Denton, chief of the APA, the major reason behind this obvious lack of motivation to "go straight" can be explained by the hardcore, unskilled prisoner's inability to find and keep a job.

Mr. Brubacher is a publications writer for the Ohio Rehabilitation Services Commission. *Help in the preparation of this article was received from Lowell Morris, BVR program specialist, Ohio Rehabilitation Services Commission.*

Parolee receives graduation certificate from Goodwill Industries official while PREP director, Mike Rist, looks on.



Many of the men returned to prison during parole have what prison authorities call a "born loser" philosophy toward life. They don't believe in themselves or society because as far as they are concerned society has never done anything for them. Upon release many are determined to do little to change this feeling they have for society.

This attitude, coupled with a lack of job skills and often a long record of underemployment, plus psychological deficiencies and other pressures make parole a time when *recidivism* can strike.

Ohio APA officials decided what the men most needed was not only job skills, which many learn while serving their prison sentences, but a period in a controlled environment. Here they could learn how to find and keep a job offering some financial reward, of job security, and self-satisfaction.

Ray Giannetta, head of Parole Supervision at APA, approached the Bureau of Vocational Rehabilitation (BVR) with the initial idea in the early spring of 1969. Together, APA officials and BVR authorities hammered out a plan to transform the ex-inmate, a State liability, into a person useful to both himself and his community.

The program became known as PREP, for Parolee Rehabilitation and Employment Project. Its purpose was to instill in the hardcore, underemployed parolee an attitude that made the working situation not only tolerable but desirable and attainable.

It was decided the program should encompass a 2-week course (later revised to 3 weeks) of instruction in job-searching techniques. BVR authorities approached Central Ohio Goodwill Industries who were able and willing to set up, structure, and teach the course material devised.

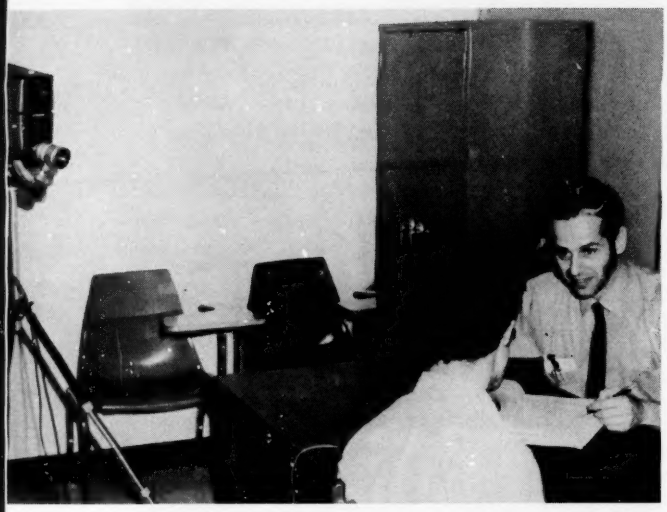
In consort, the three agencies (APA, BVR, and Goodwill Industries) sketched out a course around the general theme of job hunting knowhow. Subjects taught included how to read newspaper want ads, how to look and what to say at interviews, and what employers viewed as exemplary behavior on the employees' part. Behavioral habits such as being on time, job responsibility, and cleanliness were stressed and became an integral part of the program. Group therapy sessions and self-encountered psychological techniques also became a part of the original plan envisioned by APA.

Placement in actual job situations after completion of the 3-week program became the primary responsibility of APA that works toward this end through its parole officers who act as liaisons between APA and the State's Bureau of Employment Services (BES). The assistance potentialities of BVR and Goodwill Industries are utilized when further training or the furnishing of certain tools (wrenches, electric drills, etc.) is required for an individual to attain steady employment.

Agreement was reached on May 10, 1969, by the three agencies. Central Ohio Goodwill Industries would develop and teach the 3-week job readiness clinic, BVR would provide maintenance for the men taking the course, and APA would provide both the raw human material and all information necessary for BVR to determine whether a prospective parolee was eligible for the program.

The APA made its selection of men for the program on the basis of the following criteria: (1) The offender must be granted a parole; (2) The offender must be unskilled or underemployed; and (3) an examination of his employment record shows that he has no marketable skills.

In addition there must be evidence of one or more of the following before a man is selected for the program: (1) He has a spotty employment record; (2) He is educationally inferior; (3) He has no previous work experience; (4) He has been em-



Role-playing session is captured on video tape for later playback.

ployed for less than one year; (5) He has never earned more than $70.00 per week; or (6) His family is, or has been, on welfare.

In performing its maintenance function, BVR agreed to provide parolees with a $40.00-a-week allowance for the 3-week course. The Bureau also opted to continue payment during the first 2 weeks of subsequent employment, until the parolee received his first pay check. Spreading the program to other areas of the State, based on the success of the Columbus project, also became a BVR responsibility.

The pilot program began in September 1969. In 1970, the Ohio Bureau of Employment Services (BES) joined forces with those agencies already involved in the program. It has since become a vital supporting agency in terms of aiding the program in achieving its goal of placing parolees in jobs.

So far, of 261 men completing the program, 183 are still working at an average of $2.35 per hour. Ex-inmates discharged from parole status have bettered this while-on-parole wage by 28¢, and earn $2.63 per hour across the board. Statistics for the 30 men not presently in a working situation are not available. But, according to Lowell Morris, BVR public offender program specialist, to assume they've all been returned to prison would be a wrong.

Some indeed have violated parole and landed back in a cell, but others are either unemployed, have moved away, or for some other reason cannot yet be statistically measured. According to Morris, both APA and BVR are now compiling statistics on these men. In addition to this, Morris said 48 men who have completed the program have not yet been placed in any kind of employment. He cited the depressed economic situation as an explanation for the program's 81.5 percent placement rate.

Mention should be made concerning business support within the Columbus area and in the business community. Hal Gordon, APA's man in charge of coordinating the program with business, feels the willingness on the part of employers to hire PREP graduates has been excellent. "None of the approximately 50 employers we have approached has ever refused, when openings were available, to give qualified graduates a chance," Gordon said.

Larry Miller, director of hourly employment, at Columbus' Buckeye Steel Corporation, a major employment source for program grads admitted some had been "let go" but said overall the men graduating from PREP have equal or better work records than other men in the plant. Mr. Miller summed up an attitude found prevalent among a majority of the city's employers when he said, "I think the program is a good one; these men need a chance and our industry needs men willing to work. As they're willing to work we have a job for them."

Is the program a success? Ray Giannetta, superintendent of APA, thinks so. In an Associated Press story published in the *Columbus Dispatch* in November 1969, when the program was two months old and statistics were hard to come by, Giannetta called the project a "definite success." Superintendent Giannetta's enthusiasm has remained untarnished. In a recent interview, Giannetta hailed the program's success again and said since the program began authorities have been amazed at the way the former "born losers" have demonstrated an aptitude and desire for responsible citizenship. Giannetta urged other States to adopt the Ohio plan.

William V. Heibein, BVR director, cited the program as being one of the most successful and innovative projects in both Ohio's and the country's penal history. Many persons at BVR think PREP is illustrative of two things: First, penology at its best transforms a State liability into a useful human being capable of helping both himself and his community. And, second, interagency cooperation, coupled with community business support, invariably leads to successful rehabilitation programs. Attesting to this success record, another PREP program is now underway in the Cincinnati and Canton areas. In January 1972 new programs should get underway in Dayton and Toledo. Other communities will be included in the program as rapidly as possible.

Tom and Patricia are both accident victims. They are receiving services at the Kessler Institute for Rehabilitation while being sponsored by the N.J. Rehabilitation Commission in evening study at Seton Hall University.

Insurance Rehabilitation Pilot Project

Samuel V. Iorio

The New Jersey Rehabilitation Commission and 14 leading private insurance companies have joined in a dramatic and bold new specialized program to reach more handicapped people and help them return to their rightful independent and productive places in the community. This is a pioneering approach in which a major industry and a public agency have agreed that private carriers and a public vocational rehabilitation agency can help handicapped people overcome barriers of economic dependency. The Commission and these major insurance companies, who have offices in the State, are engaged in a team effort to provide early vocational rehabilitation services to handicapped policyholders and claimants disabled through accident, illness, or disease, which is not employment connected. It is known as the cooperative insurance-rehabilitation pilot project. It began on January 1, 1967.

When the program began there were 11 participating insurance companies but some 6 months later the number was 14. They are: Aetna Life and Casualty, Allstate Insurance Companies, American Mutual Insurance Companies, General Reinsurance Corporation, Insurance Company of North America, Liberty Mutual Insurance Companies, Nationwide Insurance Companies, New Jersey Manufacturers Insurance Company, The Prudential Insurance Company of America, Travelers Insurance Companies, Great American Insurance Companies, Hartford Insurance Group, Maryland Casualty Company, St. Paul Insurance Companies.

Interest has been shown by other insurance carriers as well and their applications are being considered.

The Commission has counselors assigned to the Division of Workmen's Compensation to provide rehabilitation services to injured workers only who are also active claimants against an insurance carrier. These counselors serve the project which was specifically designed to expand the Commission's services to disabled people not covered by the existing programs by providing vocational rehabilitation to persons eligible under any type of insurance coverage, except workmen's compensation. To our knowledge, no State has developed a program of this kind with the insurance industry.

Study Group Created

After years of intensive self-evaluation, the Nation's leading liability insurance companies became concerned about the growing claims costs and the increasing number of policyholders who were reduced to dependency through accident, illness or disease. It was also concerned about its own public image being solely a monetary relationship with its policyholders instead of a "service" relationship which had traditionally been its motto. For, in this highly competitive field of insurance, the industry came to realize that in a service-oriented society the

Mr. Iorio is the director of the project that he describes here.

extension of rehabilitation services is not only important but essential.

An insurance rehabilitation study group, which consisted of representatives from leading carriers, was created by the insurance industry to explore the possibility of a cooperative effort with Federal-State vocational rehabilitation programs. This study group made three specific recommendations to the industry: 1) vocational rehabilitation can benefit both the industry and the policyholders and, therefore, should be provided at the earliest possible time; 2) insurance companies should not attempt to set up programs which parallel those of existing vocational rehabilitation agencies but should serve their policyholders through a mutual program of referral and share costs with the State agency; and 3) a rehabilitation coordinating unit should be established within the carrier's claim operation.

The industry resolved to study the constructive potentials of vocational rehabilitation and found that it had two decisive advantages: claims check reductions and increased services to policyholders.

The study group findings led to a series of exploratory conferences between insurance carriers and the Commission. The general consensus was that a cooperative agreement would be beneficial to all concerned. Consequently, the cooperative project was born.

The Pilot Project

This pilot project is being funded by a grant from RSA, and upon the grant's termination it will be integrated into the Commission's regular program. While under project status, however, the Commission provides for all costs of diagnostic evaluation and vocational training. When physical restoration services are required, the insurance company covers that cost within the limits of liability, while additional expense of all other needed service is covered by the Commission.

The insurance company appoints a rehabilitation coordinator who screens and refers policyholders and claimants. He has been trained to recognize appropriate referral candidates for rehabilitation services. At the Commission more refined screening determines further suitability for medical and vocational rehabilitation services.

Basically, the project strives to reach more disabled people, to return persons to independence as it reduces insurance benefit costs, and to improve the industry's public image as a service provider.

Referral of Disabled Policyholders and Claimants

The project operates on a statewide basis and accepts referrals from the participating insurance carriers. Referral comes from the insurance company's rehabilitation coordinator to the project director for assignment for rehabilitation services. Other insurance carriers who wish to refer disabled policyholders and claimants can do so and are encouraged to refer them directly to the Commission's district field offices.

For definitive data purposes, Essex County was selected as the statistical control area to study the following characteristics: Type of disabilities, age range, vocational rehabilitation services provided, cost of rehabilitation services, and type of insurance coverage.

Essex County was designated because of the heavy concentration of population, the availability of comprehensive rehabilitation facilities, the training resources which are convenient to vocational restorative functions, and the nearby location of many of the participating insurance companies. An evaluation of this data could be infinitely valuable to the insurance industry and the Commission for future programing.

The Insurance Rehabilitation Coordinator

Referrals are generally screened from six major lines of insurance coverages: Auto liability, bodily injury liability, personal injury liability, accident and health insurance (individual or group), life insurance (waiver of premium), and other miscellaneous coverages.

The insurance rehabilitation coordinator has been oriented to the value of rehabilitation and is able to identify individuals who are in need of a rehabilitation program. He reviews claim reports and makes appropriate referrals.

In the screening process each coordinator is guided by the general criteria for admission to the rehabilitation program. In addition, the client should be between 16 and 60 years of age and must be available in New Jersey to participate in a program of rehabilitation services.

Effective communication and orientation training are important requirements among all participants in any successful rehabilitation program and requires an exchange of knowledge regarding

each other's respective areas of service. Project personnel learn about all lines of insurance and insurance functions, particularly the claims operations; while the insurance people are encouraged to become knowledgeable about the Commission's eligibility requirements, procedures, and programs.

Rehabilitation of the Whole Man

Early resolution of claims most often has been the traditional attitude of the insurance industry, with only limited interest in other needs of the disabled individual. Now, however, the industry recognizes changing forces in today's service-oriented society, and the necessity to rehabilitate the "whole man," which includes monetary benefits, medical restoration, and vocational rehabilitation. This new awareness of the total rehabilitation approach has stimulated the industry to recognize its advantages and oppportunities in sharing responsibility for the restoration of the disabled policyholder, with the Federal-State rehabilitation agency.

While the insurance industry has programs which may provide some aspects of rehabilitation, many of these programs may not be comprehensive, nor supervised by the professionally trained vocational rehabilitation staff. As a result of the project experience, however, the insurance industry has become knowledgeable about the Federal-State rehabilitation agencies' comprehensive rehabilitation programs, identical in each State, and how to cooperate with these resources in the best mutual interest of the policyholder and the industry. They have come to realize that professionally trained rehabilitation counselors fully understand the problems of the handicapped and can help them attain maximum possible socio-economic goals.

Program Recognition

National recognition of the project has come through insurance carrier house organs and many other industrial publications. Additional acknowledgement was enhanced through a film contracted by HEW to be used at the National Citizens Conference on Rehabilitation of the Disabled and Disadvantaged in June 1969, before 1,200 special guests.

This color film depicts the continuity of services provided by the project to a disabled client who was referred by a participating insurance carrier. Copies of this film are available upon request from the National Audiovisual Center, National Archives and Records Center, Washington, D.C.

Project statistical data are represented on the various charts. They cover January 1, 1967 to June 30, 1971. In July 1971, the project became an integral part of the Commission's program under Section two funding.

It is evident that there is a growing strength and sophistication within the insurance industry, as exhibited by the broadened acceptance of the value of rehabilitation. Insurance carriers are becoming more aware that the one positive way to reduce insurance costs is to provide the best possible comprehensive rehabilitation programs. This experience has helped to bridge the gap between the insurance industry and the Federal-State agency.

Of even greater significance than the economic gain to the insurance carrier is the restoration of the individual's ability to achieve the dignity of a meaningful contribution to his family and community. The interest and expression of mutual confidence and cooperation demonstrated during the experience of this project has proven a sound basis for future growth and benefits to the insurance industry, the rehabilitation agency, and the clientele they mutually serve. The insurance industry and this Federal-State Rehabilitation Agency have shown that in working together with a common goal, they can help disabled individuals overcome disability, dependency on claim checks, and other barriers to economic and vocational independence.

Number of Referrals Received

Control Area	430
Other Areas	888
Total	1,318

Insurance Coverage Under Which Individuals Were Referred

First Party Auto Liability (Medical Payments)	27
Third Party Auto Liability	289
Third Party General (Public) Liability	153
Accident and Health Coverages	87
Major Medical Coverage	27
Long Term Disability	59
Life (Waiver of Premium)	676
Total	1,318

Age range of referred individuals

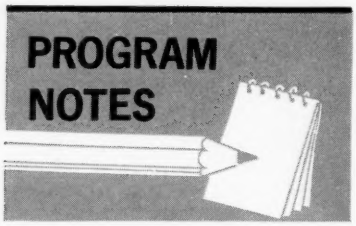
	Under 20	*20–34*	*35–44*	*45–54*	*55–60*	*Over 60*	*Totals*
Control Area	50	112	82	91	69	26	430
Other Areas	107	213	169	240	115	44	888
Totals	157	325	251	331	184	70	1,318

Disabilities of Referred Individuals

Visual	47
Cardiac	257
Orthopedic	760
Multiple Injuries	254
Total	1,318

Number of Individuals Rehabilitated

Control Area	85
Other Areas	113
Total	198 or 15%



Rural Retardates in N.H. Receive Full Services

• Satisfactory delivery of services to people in rural areas is a problem for more than one reason. The small numbers to be served, the transportation problem, and the lack of nearby resources are not likely to place these needed services at the top of a priority list in agencies already bogged down by shortage of personnel and long waiting lists.

An effective method of delivering services to residents of a rural area has been effectively demonstrated by the North Country Community Services, Inc. of Berlin, New Hampshire, which is receiving financial support under Section IV(a) of the Vocational Rehabilitation Act, as amended.

The north central country of New Hampshire is mountainous; its roads are snow-covered in winter; its population is sparse, with virtually nonexistent services for the mentally retarded. Besides, the area is classified as impoverished. The mental retardation rate is twice the national average. There is a dire scarcity of trained personnel.

To counteract this bleak picture, the North Country Community Services, Inc. utilized State, Federal, and local funds to establish three regional treatment centers. These, together with one previously existing and one established entirely by local funds, comprise a network of locally-based treatment facilities.

Over 60 children were served in the 1st year of the project, and this service was extended to include counseling services to their families and to local community resource people.

Besides the development of new behavior patterns—which is the primary goal of these centers and incorporated into the instructional programs—the centers have used the services of volunteers from two local colleges. These students received course credit in psychology and education for their volunteer work.

Student nurses were allowed to benefit from participation at the center. Thirty hours of work at a center met the 30-hour requirement for pediatric training.

Staff members benefit from training courses which keep them abreast of latest developments in services to the retarded.

A local sponsoring agency administers the center and promotes community support. The community uses the center for training purposes, and the center leans on the community for resources.

Neighborhood Youth Workers Help Reduce Violence

• In 1969 in the North Central area of Philadelphia, there were 24 deaths attributable to youth gangs. Of these 20 were linked to gangs of youths now being served by an SRS-supported project entitled "Area Youth Work Demonstration Project Involving Indigenous Personnel (Gang Control)." In early 1971, the "gang-affiliated homicides by groups served by Neighborhood Youth Workers" had dropped to eight. The youth workers "took to the streets" in June 1970.

In October 1970, 48 kids attended a basketball game. Nothing spectacular with that except that they were members of rival gangs who could have as easily attended a rumble that night. In December the same groups attended the Society Hill Playhouse. They were brought together by two neighborhood workers who involved the youth in preparing and planning these excursions.

This is only one example of how these workers are interacting with youth to get them to talk to each other, to interest them in themselves and in their communities. In re-

sponse to perceived needs of another group, for instance, another worker enlisted the help of a civic group in an attempt to found a community center. Even though their efforts have been frustrated so far, they persist and in the meantime the group has helped in securing clothing for some unfortunate youngsters whose house had burned.

The neighborhood youth worker's milieu is the same milieu in which the gang is found. It has no walls. He meets his clients wherever they are; he meets problems as they come up; he interacts with the group. But most important, the neighborhood worker does not wait for the gang to come to him, he "reaches out" to them.

Is the program having impact? Here is an exerpt from just one of the many letters praising the project's accomplishments. The person mentioned is a project area youth worker and the letter is signed by the manager of the Union Church Non-Profit Housing and Development Corporation. "Our community of North Central, for a number of years, has been plagued with gang violence. As a result of Mr. Brown's behind the scene efforts with the various gangs, he has been able to quell many gang incidents and avert much bloodshed in our area."

D.C. Inmates Learn Food Clerking From Inmates

• A new food clerk training program at the D.C. Lorton Correctional Complex, Lorton, Virginia, promises to produce first class clerks because of the intense training received by the two inmate instructors. The project is a joint effort of a group called Prayer Breakfast Group, Safeway supermarket officials, and Lorton staff members.

The program instructors were taught by Safeway personnel in a three-phase course in which the two earned pay at the regular trainee rate. They first attended the firm's Jobs Prep Center in southeast Washington where they received both on-the-job and classroom training. While attending this part of the course, the inmates were on education-release status. They attended school during the day and stayed at the D.C. jail at night.

In the next step, the two were paired with a "training buddy" as they spent 4 weeks working in different stores. During this phase, they earned $3.42 an hour. Finally, they assisted a Safeway instructor at the firm's Checker Training School.

The Safeway firm, in addition, has assisted in developing the Lorton program and is helping place course graduates in the retail food industry.

Mentally Ill Comprise Large Percent of Rehabs

• Fiscal year 1969 marked the 15th consecutive year in which the share of all rehabilitations accounted for by the mentally ill has increased. Mental illness is now the single most prevalent disabling condition among all broadly defined disabilities in the vocational rehabilitation program, according to a report of RSA's Statistical Analysis and Systems Branch (Statistical Note No. 23, March 1971).

During fiscal year 1969, some 54,603 mentally ill clients were rehabilitated. Nearly one-half of these clients were victims of psychosis or psychoneurosis, one-sixth were subject to alcoholism, and more than one-third were classified under "other character, personality, and behavior disorders." Drug addicts composed only 1 percent of the rehabilitations of the mentally ill group.

The mentally ill were twice as likely as nonmentally ill clients to have been divorced or separated and 10 times as likely to have been primarily supported by public, tax-supported institutions at the time of acceptance for vocational rehabilitation services. Aside from diagnostic procedures, training was the single service provided to the largest proportion of mentally ill clients (45 percent). The mean cost of case services paid by State agencies for the mentally ill was $581, roughly $100 less than the cost for rehabilitated clients with disabilities other than mental illness.

According to the report, ". . . fewer of the mentally ill than other clients had earnings at acceptance (but) more of them had earnings at closure."

Goodwill Hot Line in N.C. Connects Counselor, Agency

• The Goodwill Rehabilitation Center of Winston-Salem, North Carolina, has established a "counselor line," a free telephone service for the use of any vocational rehabilitation counselor who wants to talk to Goodwill about their programs, clients, or any problem the counselor might have in which Goodwill could provide assistance. The service is dubbed the "C-line," and is patterned on the "hot line." The service is direct during working hours, but recorded after working hours and on weekends.

Expansion Grants Serve 47,080 Clients in FY 1970

• During fiscal year 1970, 177 of the 208 projects funded under the RSA expansion grant program provided vocational rehabilitation services to 47,080 individuals.

Eighteen percent or 8,706 clients were not clients of State vocational rehabilitation agencies and consequently not included in the regular RSA statistical reports for fiscal year 1970.

Slightly more than one-fifth (10,569) of the clients receiving services were closed rehabilitated. Twelve percent or 1,265 of the rehabilitated clients were not State agency clients.

Rehab Acres—Minnesota's Farm Training Program

Dorothy Rigdon

At the rate of almost two a month, disabled men with good training in modern methods of farming are leaving a 500-acre farm and meat processing complex at the outskirts of Fergus Falls in West Central Minnesota and taking jobs on farms or in such farm-related businesses as feed mills, grain elevators, or implement shops, or in meat markets.

The farm is called Rehab Acres, and the magazine *The Farmer* recently referred to it as "a fair-sized mini-answer to the farm labor shortage." Rehab Acres is an adjunct of the Lake Region Sheltered Workshop in Fergus Falls. (See accompanying feature.) The workshop's director, James M. Wolfe, and Program Coordinator Ron Okerstrom, who directly supervises Rehab Acres, call the enterprise "a unique opportunity for handicapped people to work in agricultural jobs—an area of employment that has been too long neglected in our rehabilitation programs."

The rehabilitation farm is just a little over 2 years old, but it is getting a good reputation in many farm communities in Minnesota and in North Dakota, where its trainees are making good.

One such trainee spent 1½ years at the workshop and at Rehab Acres before he was ready to take a job. No wonder. He had some serious problems. He was retarded, had serious speech defects, had dropped out of high school because he couldn't do the work, and couldn't mix well with his fellow students. There was speech therapy, followed by social adjustment training, followed by months of careful training at Rehab Acres. Now that young man works on a farm in central Minnesota, is paid $150 a month plus room and board, and is pleasing himself and the farmer he works for as he helps do the general farm work.

Equally gratifying is the story of a 42-year-old man, institutionalized since he was eight years old. Through a rehabilitation unit operating in the State hospital at Fergus

Miss Rigdon is the former editor of Rehabilitation Record. *Now retired from government service, she does freelance writing. This story was developed from a first-hand visit of the facilities described in the article.*

A RURAL WORKSHOP MAKES GOOD

The Lake Region Sheltered Workshop, which runs the unique rehabilitation farm described in the accompanying article, is on the unique side in its total operation.

It had its beginnings in 1961, when the Otter Tail County Association for Retarded Children concluded that the community must have a place where the people it was concerned about could fulfill whatever potential they had. The organization had $85 in its treasury when it reached that conclusion.

Since there was scant precedent for a workshop in a rural community without the industry which normally furnishes workshop tasks in subcontract form, there was some doubt as to the feasibility of such a facility. To test this feasibility, the propsective workshop received a research and demonstration grant

Shown here are the main buildings at Minnesota's Rehab Acres.

Falls, adjoining Rehab Acres, he came into the program, receiving a variety of rehabilitation services before being trained in the meat processing operation. Now, after a lifetime shut away from other people, he is functioning independently and is supporting himself on wages made at a turkey processing plant.

Part of a pleasant countryside of lakes and rolling hills in Otter Tail County, Rehab Acres is the former State hospital farm. Now title is held by the Division of Vocational Rehabilitation (DVR), which leases the property to the Lake Region Sheltered Workshop, a private nonprofit corporation. On this produc-

from the then Office of Vocational Rehabilitation.*

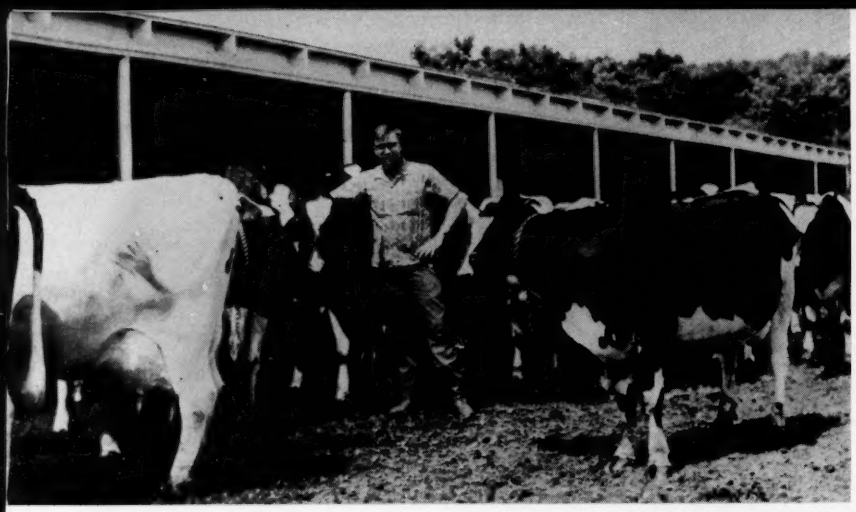
Lacking subcontracts, the new workshop began to set up its own manufacturing operations, and today is still, of necessity, largely a prime contractor.

Long ago, the feasibility of this rural workshop was shown. Now, operating in a large, 3-story building which was formerly a casket factory, the Lake Region Sheltered Workshop serves about 75 clients at-a time. Many disabilities are represented, with mental retardation and mental illness heading the list. Most are DVR clients, although the St. Cloud Veterans Administration Hospital is now sending some of its patients, including some Vietnam War veterans.

Average length of stay in the workshop is now 8 months. About 20 of the clients are employed there on a long term basis because they are not able to manage in competitive work. Job placements come from the more employable portion of the workshop's population. Fifty clients were placed in jobs last year, despite a slow local market.

Three of the workshop's singular activities:

*Research and Demonstration Grant No. 735—"To determine the feasibility of a Sheltered Workshop in rural Minnesota."



Farm manager, Duane Thompson, poses with Rehab Acres herd of Holsteins.

tive land, near the Red River Valley, Rehab Acres raises corn, oats, wheat, barley, and alfalfa. In its spacious dairy barn is a dairy herd of 145 Holsteins, with a good record of production of Grade A milk. "Milk for people," is what the trainees call it.

Rehab Acres sells 2,000 hogs a year, a cross breed of Yorkshire, Duroc, and Hampshire. Its modern farrowing house is a model of efficiency and sanitation.

Under the supervision of the farm manager, Duane Thompson, a successful Minnesota farmer, and three foremen, trainees arrive from foster homes in Fergus Falls to punch in at 5:30 a.m. They learn to do all the tasks necessary to run this large farm, one thing at a time. Rehab Acres has 16 to 18 trainees at a time on the farm itself, five or six more in the meat processing plant. Among other work, the farm crew does all the artificial insemination of the dairy cows, all the feed formulation for the hogs and cattle, and all the machine repair except really major mechanical work.

The farm is modern in every respect. If it were less so and if there were less mechanization, there could be more training stations for clients. "But we deliberately chose to run Rehab Acres according to up-to-date methods," said Ron Okerstrom, "because we want our people to be able to take a job on a modern farm and be able to do the work without a lot of additional training in running the machinery."

The farm uses all of the crops it raises and buys much additional feed. A representative of a feed company spends one full day a week at Rehab Acres, conferring on the feeding program.

Most of the Rehab Acres trainees are sent there by the DVR, which also provides funds for some of the equipment. DVR also pays for the training of the five or six men who are always on the work force of the modern meat packing plant. Operated by Bill Martinson, who formerly ran his own meat processing business, this operation butchers, cuts, packages, and freezes meat for farmers of the area and runs its own retail store, with trainees waiting on customers.

It also does other meat processing. During last hunting season, many lucky hunters brought in the deer they had killed and had the venison processed, ready for their home freezers.

A large U.S. flag flies 24 hours a day at Rehab Acres. It is lighted at night, and it is a familiar landmark to the 13,000 citizens of Fergus Falls. But to the rehabilitation officials in the State, Rehab Acres is a different kind of landmark—living proof that disabled people can be trained satisfactorily to work on farms. They hope other rural rehab programs will take note.

• Birdseed packaging, a big business in Minnesota, where cold winters with lots of snow cause long periods when birds cannot find nurture. To fill the demand for birdseed, the workshop turns out 10,000 pounds a day, in 2-pound packages. Ten or 11 clients work fulltime during the cold weather, bagging and packing the birdseed as it comes off a conveyor that has brought it from storage and will return the bags to the pickup platform.

• Plastic and aluminum signs, supplying customers in a 300-mile radius of Fergus Falls. Aluminum highway signs are turned out in quantity, and so are plastic car door signs, including those used by a major insurance company and a large church organization. There are also highly individualized signs, never in demand in quantity, like the one which says: "Graduate Ferrier." Most of the people who see that sign wouldn't know what it meant except that it is affixed to a blacksmith shop, indicating that a ferrier is a person who shoes horses.

• Unfinished furniture in enough variety to fill the pages of a sizeable catalog. It is made of Minnesota basswood, and the workshop wholesales it to 25 furniture stores in a 350-mile radius of Fergus Falls. It also does some retail selling of the furniture, which is made from scratch on the first floor of the workshop.

REHABILITATION: DYNAMIC OF CHANGE—AN ANTHROPOLOGICAL VIEW. (RD 2490) Center for Research in Education, Cornell University, Ithaca, N.Y. 14850. 112 pages.

SPECIAL INSTRUMENTATION FOR REHABILITATION OF INSENSITVE LIMBS. (RD 2312) Louisiana State University, Electrical Engineering Department, Baton Rouge, La. 70803. 119 pages.

OBESITY AS A DISABILITY: EVALUATION OF DEGREES OF DISABILITY AND TECHNIQUES OF MANAGEMENT. (RD 2224) Georgetown University, 27th and O Streets NW., Washington, D.C. 20007. 173 pages.

RECRUITMENT AND PLACEMENT OF REHABILITATION COUNSELORS. (RD 1947) National Rehabilitation Association, 1522 K Street NW., Washington, D.C. 20005. 87 pages.

COMMUNITY ORGANIZATION ACTION PLAN FOR THE MENTALLY RETARDED. (RD 1929) San Francisco Coordinating Council on Mental Retardation, 948 Market Street, Room 715, San Francisco, Calif. 94102. 141 pages.

THE OLDER HANDICAPPED WORKER. (RD 750) Jewish Employment and Vocational Service, 1727 Locust Street, St. Louis, Mo. 63103. 31 pages.

ADMINISTRATIVE AND SOCIOLOGICAL FACTORS IN ORGANIZING CHANGE. (RD 1435) Parents and Friends of Mentally Retarded Children of Bridgeport, 1135 William Street, Bridgeport, Conn. 06606. 129 pages.

STUDY OF THE ELECTRICAL CHARACTERISTICS OF SINGLE MOTOR UNITS AND SINGLE MUSCLE FIBERS IN NEUROMUSCULAR DISEASE. (RD 1614) Department of Rehabilitation Medicine, Massachusetts General Hospital, Boston, Mass. 02114. 104 pages.

THE SHELTERED WORKSHOP OF THE DELAWARE COUNTY COUNCIL FOR RETARDED CHILDREN, INC. (RD 436) Delaware County Council for Retarded Children, 2000 West Seventh Street, Muncie, Ind. 47302. 15 pages.

HEMODYNAMIC AND EXERCISE STUDIES IN DIFFUSE MYOCARDIAL DISEASE OF UNKNOWN ETIOLOGY AND CORONARY HEART DISEASE PATIENTS. (RD 2858) University of Texas Southwestern Medical School, 5323 Harry Hines Boulevard, Dallas, Tex. 75235. 56 pages.

DEAFNESS AND MENTAL HEALTH: A DEVELOPMENTAL APPROACH. (RD 2835) Langley Porter Neuropsychiatric Institute, California Department of Mental Hygiene, 401 Parnassus Avenue, San Francisco, Calif. 94122. 273 pages.

REHABILITATION HOUSE FOR THE MENTALLY ILL. (RD 1543) Dane County Association for Mental Health, 406 North Pinckney Street, Madison, Wis. 53703. 21 pages.

A STUDY OF THE IMPACT OF CONTINUING EDUCATION IN ORTHOPAEDIC SURGERY. (RD 2719) The American Board of Orthopaedic Surgery, 29 East Madison Street, Chicago, Ill. 60602. 59 pages.

ACM COMMITTEE ON PROFESSIONAL ACTIVITIES OF THE BLIND. (RD 2689) Association for Computing Machinery, 211 East 43d Street, New York, N.Y. 10017. 148 pages.

APPLICATION OF MEDICAL ENGINEERING TO AUTOMATION OF SELECTED ASPECTS OF PATIENT CARE AND REHABILITATION. (RD 2376) Case Western Reserve University, School of Medicine, 3901 Ireland Drive, Cleveland, Ohio 44122. 72 pages.

INTEGRATING EMPLOYER OCCUPATIONAL TRAINING RESOURCES IN THE REHABILITATION OF RETARDATES. (RD 2197) Jewish Employment and Vocational Service, 1727 Locust Street, St. Louis, Mo. 63103. 110 pages.

MEASUREMENT OF CARDIAC AND RESPIRATORY RESPONSES IN PHYSICALLY DISABLED AND NON-DISABLED GROUPS IN A VARIETY OF PSYCHOLOGICAL AND INDUSTRIAL CONDITIONS. (RD 2141) Human Resources Center, Albertson, N.Y. 11507. 82 pages.

A STUDY ON DRIVING RECORDS, LICENSING REQUIREMENTS, AND INSURABILITY OF PHYSICALLY IMPARED DRIVERS. (RD 2283) University of Denver College of Law, Law Center, Denver, Colo. 80204. 50 pages.

WORK ADJUSTMENT CENTER FOR OLDER DISABLED WORKERS. (RD 1747) Jewish Employment and Vocational Service, One South Franklin St., Chicago, Ill. 60606. 56 pages.

THE OFFENDER LOOKS AT HIS OWN NEEDS. (15–P–55287) Western Behavioral Sciences Institute, La Jolla, Calif. 92037. 149 pages.

DEVELOPMENT OF A RESEARCH CAPABILITY IN AN ORTHOPAEDIC-REHABILITATION TREATMENT AND TRAINING CENTER. (RD 1438) Orthopaedic Hospital, 2400 South Flower St., Los Angeles, Calif. 90007. 22 pages.

ADAPTION OF YOUNG CARDIACS. (RD 2839) Children's Hospital Medical Center, 300 Longwood Ave., Boston, Mass. 02115. 83 pages.

COMMUNICATION AND COMMUNITY ORGANIZATION ON NEVADA INDIAN RESERVATIONS. (RD 2793) Inter-Tribal Council of Nevada, Inc., 1995 East Second St., Reno, Nev. 89502. 107 pages.

Rehabilitation in Renal Failure

Jean M. Morgan, M.D.

AT THE FIRST International Conference of Nephrology in Evian, Switzerland, in 1960, Dr. Belding Scriber reviewed a unique program being conducted in Seattle, Washington, whereby persons without kidney function were being maintained on an artificial kidney indefinitely and were able to return to the community as productive citizens. Although the artificial kidney had been used for many years to treat reversible or acute renal failure, it had not been used before for long term life support.

The demonstration that patients could be kept alive and functional over long periods by such means so stimulated the imagination of the American public and press, that the U.S. Public Health Service provided the support for the establishment of several such centers to test the practicality and define the problems of such a complicated artificial way of life. The University of Alabama in Birmingham was selected for the establishment of one of these centers and a 5-bed maintenance dialysis unit was opened in August 1965.

Patients suitable for this form of treatment were carefully selected by a team consisting of Dr. H. Walker Brown, the program director, as well as a nurse, dietitian, social workers, psychiatrist, psychologist, and vocational rehabilitation counselor. Patients were to be between the ages of 15 and 50 with life-threatening renal failure, but no other serious illness. They had to be willing and sufficiently motivated to cooperate with therapeutic restrictions and rehabilitative aspects of the program, and had to live close enough to the center to come for treatment twice weekly. Over the next 2 years, 16 patients qualified for the program and were begun on treatment.

Although the Seattle experience had proved that patients could live fairly comfortably sustained entirely by the artificial kidney, it was not at all certain that such individuals would be psychologically sound or that general health would permit functional recovery at home or on the job. Therefore, the program at the University of Alabama was designed to test the rehabilitation potential and problems of this highly artificial way of life. Support for the study was granted from VRA in 1966. Some of the experiences and findings of that study are the subject of this paper.

A complete initial evaluation was conducted on each patient, which included psychologic testing and a psychiatric interview. No patient was excluded for psychologic reasons nor for low intelligence, provided it was felt that he could cooperate with dietary and other medical restrictions of the program. A social worker visited the families and homes of the patients. A rehabilitation counselor made sure that each employer would be willing to take the patient back on the job after the institution of therapy and that the job requirements were not too strenuous to permit return to gainful employment.

Although uremia is symptomatically controlled by the artificial kidney, it should be emphasized that twice weekly dialysis permits only fluctuating chemical control of the uremic state. Such patients remain anemic, chemically imbalanced, and have

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disturbing fluctuations in blood pressure and weight associated with the dialysis procedure. This makes strenuous physical exertion impossible and appropriate job placement is essential.

The dialysis patient has an additional handicap in that he must wear plastic cannulas (tubes) inserted into an artery and vein of an extremity to permit passage of his blood through the artificial kidney. This is covered with a bandage when the patient is not attached to the blood-flow lines of the machine, and they must be kept clean to avoid infection. One patient who worked as a meat cutter and another who was a welder had difficulty avoiding trauma and contamination to the cannula site. Where necessary, job reassignments were worked out to make it possible for patients to function productively within their limits.

All dialyses were conducted at night to allow full employment, but many patients, and particularly those women who functioned only as homemakers, reported that the day after dialysis was difficult. Excessive weakness or post-dialysis headache incapacitated them for at least a part of that day. In general, however, all except two patients functioned effectively. One patient, A.N., obviously had a great deal more heart disease than was appreciated at the time he was accepted into the program. He remained a cardiac invalid and was never rehabilitated.

An additional patient, a 16-year-old student, R.S., had had lifelong illness including tuberculosis, as well as secondary infection of the urinary tract. His course was so complicated by medical difficulties, and his level of education had been so poor because of the long illness, that no rehabilitation was possible. Both these patients died during the study and emphasize the fact that the presence of diseases or complications other than the primary kidney disease make a person unsuitable for this type of medical care.

In summary, all but 2 of 16 patients, or 87 percent, were able to maintain a satisfactory level of rehabilitation as judged by performance as homemaker and mother or ability to hold a job providing satisfactory personal or family support. This was in spite of the fact that there were frequent short term hospitalizations for minor complications and numerous medical difficulties. Almost all of the clients returned to the same occupation that they held prior to dialysis. Some of the occupations included warehouse clerk, forklift operator, electrician, teacher, and air-conditioner repairman. At the time of this writing, 10 clients are working, two are deceased, two recently received transplants, and two are not working.

Psychologic and psychiatric testing were repeated at 6-month intervals, and most patients reached an adequate level of adjustment into the program within 6 months. Although there were temporary emotional upsets and mood changes, these tended to be related to temporary physical problems and setbacks. When patients were doing well physically, their attitude and acceptance of the program were satisfactory. In general, it was remarkable how patient and cheerful the patients remained despite their many medical complications. This was particularly true when there was good family support in the home. The consistently dedicated and loving encouragement provided the patients by their families was obviously of immense importance in making this complicated existence a satisfactory way of life.

Since the patient's overall adjustment and effectiveness both at home and on the job seemed to depend on the adequacy of medical control of complications, the principles of good medical management became paramount. It soon became apparent that long periods of dialysis to adequately control uremia were essential. This required two 12-hour periods weekly for women, and 14-15 hours twice weekly for the men.

Such long dialysis periods were taxing to the patients at first. Much patient instruction about dialysis and its limitations from the nurses and staff was necessary to make this an acceptable routine. Equally important was strict adherence to dietary limitations. For some of the patients, in particular the forklift operator who could not read, this required a great deal of instruction and supervision on the part of the dietitian and the unit nurses. The care of the cannulated extremity was critical, since clotting and infection in the cannulas remained the major cause of loss of time from work. Complications could be minimized by compulsive care of the cannulas on the part of the patients. Thorough instruction and surveillance by nursing personnel was essential.

Staffing in the unit was optimal with 8 nurses, 4 dialysis technicians, a physician who devoted at least half his time to the program, and part-time services of the dietitian, social worker, and psychologist. There is no question that such a high staff to patient ratio was critical in the success of the program. It provided maximum time for complete instruction of the patients concerning the nature of their illness, the problems and requirements of dialysis, the

necessity of strict adherence to the diet, and compulsive cannula care, as well as reenforcement of the emotional acceptance of dialysis as a way of life. The constant emotional support generated in the close relationship between the patients and nursing personnel was essential during periods when patients experienced complications and medical difficulties.

The sustained general good health and nearly complete rehabilitation of all but two patients in this program was a much better result than reported from many other programs around the country, but the overall cost remained high. Incenter dialysis now costs up to $15,000 per patient per year, and with 5 beds available, only 15 patients could be treated indefinitely. Since more than 1,000 patients die in Alabama of kidney disease each year, such a service was totally inadequate to fill the need. If instead of incenter dialysis, each of the center beds were to be used for home training, some 120 patients could be trained and sent out on home dialysis over a 10-year period. If each bed were used to prepare patients for kidney transplantation, and assuming that donor kidneys were available, 30–50 patients per year could be treated.

Fortunately, reliable renal transplantation became available at the University of Alabama in 1968, and all patients were offered the opportunity to elect it. Since that time it has been possible to transplant 5 of these patients. Four received their kidneys from living relatives and one from a cadaver. One kidney was lost through technical difficulties at the time of surgery and never functioned. The patient was returned to dialysis and remains in relatively good condition. The other four transplants worked successfully immediately and are still functioning. Abbreviated summaries of two patients who have been successfully transplanted follow as an example of some of the problems and complications occurring both on dialysis and after transplantation.

• H.F., a 38-year-old male forklift operator, was maintained on hemodialysis for a total of 38 months. During the first year, blood pressure control was very difficult, making it impossible for him to work until his kidneys were removed in January 1967. Following this he had an excellent year of employment with minimum difficulties, but began having recurrent cannula infections and obstruction. This produced recurrent hospitalization through 1968 and early 1969. He elected for transplantation and was given a kidney from a cadaver in September 1969. After 18 months he has excellent renal function and good blood pressure control. He is fully employed as a forklift operator.

The first 6 months after his transplant were complicated by the onset of diabetes induced by the corticosteroids used to prevent rejection and glaucoma associated with the same medication. Both of these problems have resolved, however, and he no longer requires insulin. He has had excellent results with dialysis and transplant and is rehabilitated.

• T.H., a 39-year-old male lineman working for Alabama Power Company, was treated for 26 months on dialysis before he received a kidney from his sister. During the first 6 months of dialysis he had had severe problems with neuropathy in his legs, producing loss of nerve conduction, reflexes, and muscle strength. Despite this he was able to continue his employment.

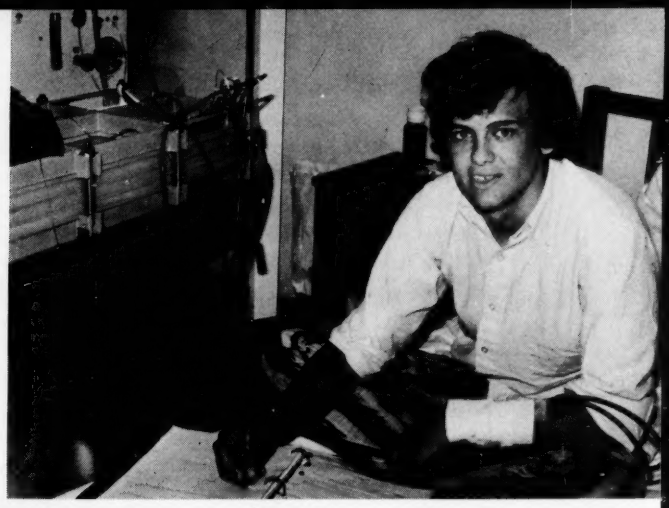
He had become depressed with dialysis because of the long hours in the unit away from his family and a long commuting distance and desired a transplant. He received a well matched kidney from his sister which functioned very well. However, an obstruction to the new kidney required surgery. He was recovering well at 6–8 months when he inadvertently fell and fractured his hip. This produced prolonged disability accompanied by considerable depression. He now is having some difficulty with his vision because of cataracts due to the steroids he requires to maintain the transplant. He was partially rehabilitated on dialysis and although one would have to class his transplant as successful, his postoperative course has been excessively complicated and discouraging to him. His rehabilitation potential has not been fully met since transplantation.

Of the other two transplantations, one was totally rehabilitated, and he enjoyed excellent results and was remarkably free of major complications throughout. The fourth, a 39-year-old welder and mechanic is only partly functional at present and cannot be considered rehabilitated.

In conclusion, one might say that rehabilitation can certainly be accomplished for patients who require maintenance on the artificial kidney and have no functioning renal tissue of their own. It requires good selection of patients, a high staff-patient ratio with maximum effort at education, phychologic support, and excellent management of medical complications and problems.

The costs and pressure for more efficient use of existing facilities make incenter dialysis impractical. Home dialysis, although not discussed here, is

HOME DIALYSIS



David Lammons, a pharmacy student at the University of Mississippi, does not let dialysis interfere with his studies.

PATIENTS with terminal kidney failure learning to use home kidney machines at Mississippi's University Medical Center kidney dialysis home unit training center must do considerable "home work."

Four to five patients simultaneously undergo training in the operation of the life-saving machines. Upon conclusion of an 8-week training session, each patient takes one of the machines home with him—for keeps. The machine, the training equipment, and the staff are paid for chiefly by the Vocational Rehabilitation Division. The center is operated by the Medical Center. The Mississippi Kidney Foundation and other organizations assist in the support of the kidney dialysis program.

Each patient must learn exactly how the machine operates and how to maintain it. He also learns to keep records of his treatment.

During the last 2 weeks of the patient's training, a relative or friend who will assist him in his home undergoes training in the operation of the machine.

The machines purify the patients' blood, making it possible in most cases for them to live normal lives. Each patient must spend approximately 24 hours weekly on the machine.

Before the home machines became available, all patients receiving dialysis in Mississippi had to go to the University Medical Center twice weekly for 12-hour sessions.

By using a machine in his own home, the kidney patient can divide the 24 hours into three 8-hour periods, and undergo dialysis while he sleeps.

The Artificial Kidney Home Unit Training Center classes began on April 20, 1970. Each class comprises 6 weeks of training and 2 weeks of unattended dialysis in the hospital. A total of 36 persons have completed their training, with four more expected to complete the course soon.

Of these, 26 have been vocational rehabilitation clients. One is a 12-year-old junior high school student served through a program for dependents of military personnel; 3 are receiving services through the Veterans Administration; and 3 are being served through private donations from his home community. One is being served under the military. One VR client has died since completing training.

Most of the home unit machines have been placed in the homes of the clients. There are 3 trailer units, however, one each in Columbia, Greenville, and West Point. Each unit services two patients.

Hospital satellite units are also located in Pascagoula, Tupelo, and Hattiesburg and serve essentially the same function as the trailer units.

The type of dialysis machine formerly purchased for clients has been replaced by a smaller, more compact machine which can dialyze two persons simultaneously.

This feature is based on an article appearing in *Rehab Review* quarterly publication of Mississippi's Vocational Rehabilitation Division.

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equally rewarding and satisfactory if a well-trained staff is available for patient and family instruction and a hospital unit provides for backup when home equipment fails or complications occur. Home dialysis reduces costs, keeps the patient with his family, and frees equipment in the hospital for other patients in home training or in preparation for transplant. With the growing pressure of patients requiring such services and the growing costs of hospital care, it is inconceivable that money will again be available for such study of long term, in-center dialysis as was done here. It is indeed fortunate that recent progress in renal transplantation and the growing availability of home training and home equipment make it possible to treat an ever growing number of patients and return them to their communities as useful citizens.

See box, next page.

Since Dr. Morgan wrote this article about a year ago, a number of changes have occurred in the status of the patients. They are:

- Five remain on dialysis; all women; only one of whom is employed outside the home.
- Five have been successfully transplanted and all but one are doing very well and are fully employed.
- One was successfully transplanted but died of a myocardial infarction two years later.
- Five patients died on dialysis after 18 months—5 years of treatment.

WELL SAID; WORTH SAYING: There is no lifetime commitment made in a day, but rather a gathering, from day to day, of energies and faculties, which are focused on a central idea. To be committed is to each day offer that which is best in you to the task at hand. Tomorrow's services cannot be offered today, nor can what happened yesterday extend beyond the time that was yesterday's time. (Alice M. Turiello in "A Commitment to Service in Rehabilitation: A Statement of a Philosophy" in Rehabilitation Literature, May 1970.) . . . . . people can be disabled by criteria established by the medical profession and not by their actual functional incapability. The fact that disability benefits can become a motivating force to reinforce the concept of disability is a social question of a great significance. There still remains, however, a group of other individuals who have been disabled merely by medical classification, based upon less than perfect measurements of functional residual capacities. (Paul Rubenstein, M.D., in the foreword to The Rehabilitation of Cardiac Pateints, final report of research and demonstration project 1991.) . . . . I build on a fantastic assumption/of a time yet unseen/ and untouchable,/ but there is a self limitation/ that is fast to harden:/ tomorrow will never be/ a Rose Garden. (Bob Feaster, from a poem "Hereafter, The Here and Now" in New Life, June 1970, Addicts Rehabilitation Center, New York City.)

ONE MILLION of anything is a lot! When the million represents disabled persons served in one fiscal year that's even more significant! Actually, 1,001,660 disabled persons were served by the State-Federal program of vocational rehabilitation in fiscal year 1971, marking a first in the program since its establishment in 1920. The landmark number breaks down to 291,292 closed rehabilitated, 96,721 closed not rehabilitated, and 613,647 carried over for continuing services in fiscal year 1972.

STROKE. According to the American Heart Association the prime candidate for a stroke is a person with high blood pressure. The Association lists these "high risk" conditions: (1) high blood pressure, (2) a history of brief, short-lived "small strokes," (3) a variety of heart abnormalities, (4) hardening of the arteries in other parts of the body, such as heart, neck, and legs, (5) diabetes, and (6) increased levels of blood cholesterol and other fats. Other less well documented risk factors include: (1) cigarette smoking, (2) high levels of red blood cells, and (3) the presence of gout.

PLANT PATHOGENS 80 times smaller than any known virus have been discovered by U.S. Department of Agriculture scientists. The tiny particles called "viroids," the scientists believe, may shed light on human diseases such as multiple sclerosis, infectious hepatitis, and some forms of cancer.

JOB PLACEMENTS through the National Easter Seal Society for Crippled Children and Adults have nearly doubled during the last year. Over a thousand persons were placed in 1971 as compared to 638 in 1970. In addition 17,308 persons received rehabilitation services during 1971 through the society.

U.S. GOVERNMENT PRINTING OFFICE: 1971

REHABILITATION RECORD

The weakest ink is better than the strongest memory

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Published by

Rehabilitation Services Administration

Edward Newman
Commissioner

Ron Bourgea, Editor
Room 3213, HEW South Building
Washington, D.C. 20201

Use of funds for printing the Rehabilitation Record was approved by the Director of the Bureau of the Budget, January 5, 1966. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price 55 cents (single copy). Subscription price: $3 per year, 75 cents additional for foreign mailing.

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REHABILITATION RECORD

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service

Rehabilitation Services Administration

Washington, D.C. 20201